THE ADVISORS GUIDE TO SOCIAL INSURANCE PROGRAMS
(2025 EDITION)

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CHAPTER 1

INTRODUCTION

Overview

The Old-Age, Survivor, and Disability Insurance (OASDI)–which for most Americans means Social Security–is the largest income-maintenance program in the United States. Based on social insurance principles, the program reaches almost every family, and at some point, will touch the lives of nearly all Americans. Today, nearly one in six Americans receive a benefit from Social Security, including 90% of those age 65 and older, making Social Security the #1 federal entitlement program.

This chapter will examine the history of Social Security (OASDI), its expansion, and its evolution.

Learning Objectives

Upon completion of this chapter, you will be able to:

- Define the history and purpose of Social Security.
- Introduce the expansion of Social Security benefit programs; and
- Determine who is responsible for administering the Social Security programs.

History of the Social Security Program

The Social Security program began on August 14, 1935, when Congress passed, and President Franklin D. Roosevelt signed the Social Security Act (now codified as 42 U.S.C. Ch. 7). This act was originally named the Economic and Security Act but was changed during Congressional consideration of the bill.

Initially, the Social Security program intended to provide financial security for older Americans. It was designed to help compensate for limited job opportunities available to older people in our society, and it was intended to help bridge the gaps created by the disappearance of the multigenerational family household; this breakup was caused in large measure by the need for American workers to move around the country to find decent employment.

The Act provided benefits to retirees and the unemployed and a lump sum benefit at death. During this time, the U.S. was going through the "Great Depression," and many older Americans fell into deep poverty. While the Social Security program could not solve this problem immediately since many benefits would not be payable for several years later, the program was intended to prevent such a situation from recurring. The Act also gave money to states to assist aged individuals (Title I), for unemployment insurance (Title III), for Aid to Families with Dependent Children (Title IV), for Maternal and Child Welfare (Title V), for public health services (Title VI), and the blind (Title X).

Initially, the Social Security Act provided only retirement benefits and covered about 60 percent of the country's workers. Today, about 90 percent of U.S. wage earners are covered by Social Security. The original benefit levels set were never enough to guarantee a standard of living above the poverty level.

The first reported Social Security payment was to Ernest Ackerman, who retired only one day after Social Security began. Five cents was withheld from his pay during that period. He received a lump sum payout of seventeen cents from Social Security.

The first monthly payment was issued on January 31, 1940, to Ida Fuller of Ludlow, Vermont. In 1937, 1938, and 1939 she paid a total of $24.75 into the Social Security system. Her first check was for $22.54. After her second check, Ms. Fuller has already received more than she contributed over the three-year period. She lived to be 100 and collected a total of $22,888.92.

Expansion and Evolution

In 1939, Social Security benefits were extended to a retired worker's spouse (survivor benefits) and minor children (dependent benefits). As a result of frequent legislation, benefit levels also increased to reflect changes in the cost of living and real terms.

In the original 1935 law, due to the law's constitutionality, the taxing provisions were included within the law as a separate title, Title VIII. With the beginning of the tax rate in 1937, the government began collecting taxes of 2 percent on wages up to $3,000 per year, split evenly between the employer and the employee (1 percent paid by each, respectively). As part of the 1939 Amendments, the Title VIII taxing provisions were removed from the Social Security Act and placed in the Internal Revenue Code. Since it wouldn't make any sense to call this new section of the Internal Revenue Code "Title VIII," it was renamed the "*Federal Insurance Contributions Act*" (FICA).

The 1939 Amendments

The 1939 Amendments also established the Social Security Trust Fund (Title VIII) for any surplus funds. The managing trustee of this fund is the Secretary of the Treasury. The money could be invested in both non-marketable and marketable securities.

Amendments of the 1950s

After years of debate, in the Amendments of 1950, Social Security was expanded to include domestic labor, household employees working at least two days a week for the same person, nonprofit workers, and the self-employed. Hotel workers, laundry workers, all agricultural workers, and state and local government employees were added in 1954.

The Social Security Amendments of 1954 initiated a disability insurance program that provided individuals with additional coverage against economic insecurity. At first, there was a disability "freeze" of a worker's Social Security record during the years when they were unable to work. While this measure offered no cash benefits, it did prevent such periods of disability from reducing or wiping out retirement and survivor benefits.

On August 1, 1956, the Social Security Act was amended to provide benefits to disabled workers aged 50-64 and disabled adult children.

In addition, below are some additional changes the 1956 Amendments made to the Social Security programs:

- The FICA tax rate was raised to 4.0% (2% for the employer, 2.0% for the employee).
- Provided monthly benefits to permanently and totally disabled workers aged 50-64.
- Provided monthly benefits to disabled children aged 18 or over of retired or deceased workers if their disability began before age 18.
- Women were allowed to retire at 62 with benefits reduced by 25%.
- Widows of covered workers were allowed to retire at 62 without the reduction in benefits; and
- Set the widow's unreduced benefit amount at 75% of the deceased worker's PIA.

Amendments of the 1960s

In September 1960, President Eisenhower signed a law amending the disability rules to permit the payment of benefits to disabled workers of any age and their dependents. By 1960, 559,000 people were receiving disability benefits, with the average benefit amount being around $80 per month.

In 1961, retirement at age 62 was extended to men. Since the number of beneficiaries and their benefit levels rose, taxes also needed to rise, especially since the program had no significant accumulated funds on hand to finance these increases. At that time, the tax rate was increased to 6.0%. It also raised the unreduced benefit amount for widow(er)'s to 82 ½ percent at age 62. This benefit was not subject to reduction for age.

In 1962, the changing role of the female worker was acknowledged when dependent husbands, widowers, and children could collect the benefits of covered women. These individuals, however, had to be able to prove their dependency.

Medicare was added in 1965 by the Social Security Act of 1964, part of President Lyndon B. Johnson's "Great Society" program. Social Security was changed to withdraw funds from the independent "trust fund" and put it into the General Fund for additional congressional revenue.

In 1965, the age at which widows could begin collecting benefits was reduced to 60. Benefits were reduced 5/9 of 1% for each month prior to age 62. Widowers were not included in this change. When divorce, rather than death, became the major cause of marriages ending, divorcees were added to the list of recipients. Divorcees over the age of 65 who had been married for at least 20 years remained unmarried and could demonstrate dependency on their ex-husbands received benefits.

The government adopted a unified budget in the Johnson Administration in 1968. This change resulted in a single measure of the government's fiscal status, based on the sum of all government activity. The surplus in Social Security trust funds offset the total debt, making it appear much smaller than it otherwise should.

Amendments of the 1970s

The 1970s were a watershed decade in program history. Benefits increases legislated by Congress accelerated sharply in the early 1970s. When combined with difficult economic conditions and a fully mature Social Security program caused concern about the program's financial status.

In 1972 two important sets of amendments were enacted. These amendments created the Social Security SSI and introduced automatic Cost-of-Living Adjustments (COLAs).

The bill creating the SSI program also contained important provisions for increasing Social Security benefits for certain beneficiaries (primarily aged widows and widowers). It also provided the following change in benefits:

- A minimum retirement benefit.
- An adjustment to the benefit formula governing early retirement at age 62 for men, to make it consistent with that for women.
- Extension of Medicare to those who received disability benefits for at least two years and to those with Chronic Renal Disease.
- Liberalized the Retirement Test; and
- Provided for Delayed Retirement Credits to increase the benefits of those who delayed retirement past age 65.

The separate bill creating automatic COLAs also provided automatic increases in the earnings subject to Social Security taxes and an automatic adjustment in the wage-base used to calculate benefits. This second adjustment was put into the law as a sort of

companion to COLA. The COLA adjusts for increases in prices, whereas the wage-based adjustment corrects for increases in wages. The purpose of the COLA was to maintain the purchasing power of benefits already awarded. The purpose of the automatic adjustment in the wage base was to maintain the relative value of Social Security benefits for future applicants.

When Congress approved by overwhelming majorities a 20 percent increase in benefits for 27.8 million Americans (much more than was justified by inflation), the average payment per month rose from $133 to $166. The bill also set up a cost-of-living adjustment (COLA) to take effect in 1975. This adjustment would be made yearly if the Consumer Price Index increased by 3% or more. This addition was an attempt to index benefits to inflation so that benefits would rise automatically.

Unfortunately, the procedure for adjusting price and wage increases contained a flaw that resulted in future benefit levels soaring out of control. Indeed, it became apparent that if the trends of the mid-1970s continued, future Social Security beneficiaries could end up receiving more in their monthly retirement benefit than their gross salaries while working.

President Carter's 1977 Amendments signed into law attempted to correct this problem, known as "double indexing." The initial benefit level was allowed to retain some of the unintended increases that resulted from the operation of the faulty law during 1972-78 and were permanently higher than the pre-1972 level. However, while individuals collecting Social Security born between 1911 and 1916 were grandfathered from the fix, the people born after 1917 but before 1922, informally known as "The Notch Babies," saw a reduction in their benefits due to fixing the "double indexing."

> *"Now this legislation will guarantee that from 1980 to 2030, the Social Security funds will be sound."*

This, of course, did not turn out to be the case. The financial picture declined almost immediately, and by the early 1980s, the system was again in crisis (sound familiar).

If you notice, all the Congressional amendments to Social Security mentioned above took place in even-numbered years. This coincided with election years since the bills were politically popular. However, by the late 1970s, this era was over. For the next three decades, projections of Social Security finances would show large, long-term deficits. From the early 1980s, the program flirted with immediate insolvency. Social Security reform now meant politically unpopular tax increases and benefit reductions. From this point forward, amendments to Social Security would occur in odd-numbered years, far removed from election periods. Social Security became known as the "Third Rail of American Politics," and touching it became political suicide.

Amendments of the 1980s

From 1975 through November 1982, the trust funds dropped from $46 billion–about one year's outgo at the beginning of the period–to zero. Special legislation enacted at the end

of 1981 allowed Social Security to borrow funds temporarily from the Medicare Hospital Insurance program. Loans totaling $12.4 billion in 1982 permitted Social Security benefit payments to be made until permanent changes could be enacted into law. The 1981 amendments were of a "stop-gap" nature, while the 1983 amendments were intended to solve the problem completely.

The 1981 Amendments significantly reduced benefit outgo in the short-range by the following actions:

- The regular minimum benefit (an initial PIA of $122) was eliminated for all newly eligible after 1981, except for certain covered members of religious orders under a vow of poverty.
- Benefits for children ages 18-21 who were still in school (mainly college) were eliminated by a gradual phase-out, except for high school students aged 18.
- Mother's and father's benefits with respect to non-disabled children terminate when the youngest child is age 16 (formerly 18).
- Lump sum death benefit payments were eliminated, except when a surviving spouse who was living with the deceased worker is present or when a spouse or child is eligible for immediate monthly benefits.
- Sick pay in the first six months of illness is covered wages.
- Lowering of the exempt age under the earnings test to age 70 in 1982 was delayed until 1983; and
- The Workers' Compensation offset against disability benefits was extended to several other types of government disability benefits.

Further action beyond the 1981 amendments was essential to restore both the short-range and long-range solvency of the OASDI program. President Reagan established the National Commission on Social Security Reform–a bipartisan group appointed by him and the Congressional leadership–to make recommendations for its solutions. Such recommendations were adopted almost in their entirety in the 1983 act. **Note:** Alan Greenspan was the chairman of the commission.

The 1983 amendments were based on the NCSSR "*Report of the National Commission on Social Security Reform*." http://www.ssa.gov/history/reports/gspan.html. The NCSSR made the following recommendations to reform and strengthen Social Security's financial condition:

- Payroll taxes were increased in 1984, 1988, and 1989.
- Coverage was expanded to include most of the remaining non-covered groups, including federal government employees hired in 1984 and after.
- Cost-of-living benefit increases were delayed by six months each year (i.e., will always be in checks for December payable in early January).
- The normal retirement age (NRA) was raised gradually from age 65 for workers born before 1938 to age 67 for workers born after 1959. Age 62 is retained as the early-retirement age, but with appropriate, larger actuarial reductions.
- Deemed all disabled widow(er)s to be age 60 beginning January 1, 1984.

- Eliminated the additional reduction for the period between age 50 and age 60.
- Increased full retirement age for widow(er)s benefits for people born after 1/1/1938.
- Increased the full retirement age for widow(er)s benefits for people born after 1/1/1940; and
- Benefits became subject to federal income tax for the first time, but only for those beneficiaries with substantial incomes from other sources. The income from that taxation of benefits was returned to Social Security.

The 1983 Amendments also included a provision to exclude the Social Security Trust Fund from the Unified Budget (in political jargon, it was proposed to be taken "off-budget"). Yet today, Social Security is treated like all the other trust funds of the Unified Budget. This provision also provided for the exemption of Social Security and portions of the Medicare trust funds from any general budget cuts beginning in 1993. This change was one way of trying to protect Social Security funds for the future.

As a result of these changes, particularly the tax increases, the Social Security system began to generate a large short-term surplus of funds, intended to cover the added retirement costs of the "Baby Boomers." Congress invested these surpluses into special series, non-marketable U.S. Treasury securities held by the Social Security Trust Fund. Under the law, the government bonds held by Social Security are backed by the full faith and credit of the U.S. government. Because the government had adopted the unified budget during the Johnson administration, this surplus offset the total fiscal debt, making it look much smaller. There has been significant disagreement over whether the Social Security Trust Fund has been saved or used to finance other government programs and other tax cuts.

The Senior Citizens' Freedom to Work Act of 2000

The Senior Citizens' Freedom to Work Act of 2000 (Public Law 106-182) was signed into law on April 7, 2000, by President William Clinton. The Act eliminated the Retirement Earnings Test (RET) for those beneficiaries at or above full retirement age (FRA). The RET still applies to those beneficiaries below NRA.

In addition, the Act introduced a new concept called "voluntary suspension" of benefits, allowing those who already started Social Security benefits to stop their payments and earn delayed retirement credits (DRCs). The "voluntary suspension" of benefits unleashed a number of "loopholes," allowing beneficiaries to choose from several claiming strategies that could maximize their benefits. These claiming strategies became known as File-and-Suspend; Claim Now, Claim More Later; and Restricted Applications for Spousal Benefits.

The Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010

The Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 (Public Law 111-312) enacted December 17, 2010, also known as the 2010 Tax Relief Act, included a provision that would provide a temporary, one-year reduction in the FICA payroll tax. The normal employee rate of 6.2 percent was reduced to 4.2 percent. The rate for self-employed individuals was reduced from 12.4 percent to 10.4 percent. The negative revenue impact of this measure was estimated at $111 billion.

The Temporary Payroll Tax Cut Continuation Act of 2011

Among other provisions, the Temporary Payroll Tax Cut Continuation Act of 2011(Public Law 112-78) extended for two months (i.e., through February 2012) the temporary 2 percentage point reduction in the Social Security payroll tax for employees and the self-employed in effect for the calendar year 2011 under Public Law 111-312. The reduced payroll tax rate was applied to the first $18,350 of covered wages (an amount equal to two-twelfths of the 2012 taxable wage base of $110,100). The employer's share of the payroll tax was not affected. The law provided general revenue transfers to the Social Security trust funds in amounts needed to protect the trust funds from a loss of payroll tax revenues due to the temporary reduction.

Middle Class Tax Relief and Job Creation Act of 2012

The Middle-Class Tax Relief and Job Creation Act of 2012 (Public Law 112-96), also known as the "*payroll tax cut*," was signed by President Barrack Obama on February 22, 2012. Among other provisions, the Act further extended the temporary 2 percentage point reduction in the Social Security payroll tax for workers (described above) through the end of the calendar year 2012. The law provided general revenue transfers to the Social Security trust funds to make up for the foregone payroll tax revenues.

The Bipartisan Budget Act of 2015

The Bipartisan Budget Act of 2015 (Public Law 114-74), signed into law on November 2, 2015, by President Barrack Obama, makes several changes to the Social Security programs. Among these changes, Congress has set out to shut down the "*loopholes*" created by the "*voluntary suspension*" of benefits, authorized by the Senior Citizens' Freedom to Work Act of 2000.

Under Subtitle C. "*Protection Social Security Benefits*," Section 831, "*Closure of Unintended Loopholes,"* a new provision under Section 202 (r)(1)) extends the "*deemed filing"* rule to age 70. In addition, a new provision has been added to the Social Security Act (Section 202(z)) that in cases in which a person who has attained FRA files for retirement benefits and requests that those benefit payments be suspended, no benefits

will be payable to that person based on another person's work record during the period of benefit suspension.

In addition, Section 833. "*Reallocation of Payroll Tax Revenue*" will allow the temporary reallocation of the Social Security payroll taxes so that a larger share is deposited in the Disability Insurance (DI) Trust Fund to extend the life of this trust fund beyond its current predicted exhaustion in 2016. Under this provision, the allocation of the 12.40% Social Security payroll tax assigned to the DI Trust Fund increases from 1.80% to 2.37%. The Old-Age and Survivors Insurance (OASI) Trust Fund allocation decreases from 10.60% to 10.03%. These changes lasted through 2018.

Social Security Fairness Act of 2023

On January 5, 2025, President Joe Biden signed the Social Security Fairness Act into law, effectively repealing the Windfall Elimination Provision (WEP) and the Government Pension Offset (GPO).

These provisions previously reduced Social Security benefits for individuals receiving pensions from employment not covered by Social Security taxes, such as certain federal, state, and local government positions. The elimination of WEP and GPO ensures that public servants—including teachers, firefighters, police officers, and postal workers—receive full Social Security benefits without reductions due to their non-covered pensions.

The repeal of these provisions is expected to significantly increase retirement income for nearly 3 million public service retirees.

For example, the Congressional Budget Office estimates that by December 2025, affected individuals could see their monthly benefits increase by $360 to over $1,190.

This legislative change addresses long-standing concerns about the fairness of benefit reductions for public employees who have contributed to Social Security through other employment. However, some critics argue that the increased payouts may strain the Social Security Trust Funds, potentially accelerating insolvency projections.

Social Security Program Principles

Certain fundamental principles have shaped the development of the Social Security program. These basic principles are largely responsible for the program's widespread acceptance and support:

- *Work Related*–Economic security for workers and their families is based on their work history. Entitlement to benefits and the benefit level are related to earnings covered in work.

- *No Means Test*–Benefits are an earned right and are paid regardless of income from savings, pensions, private insurance, or other forms of non-work income.
- *Contributory*–The concept of an earned right is reinforced by the fact that workers make contributions to help finance the benefits.
- *Universal Compulsory Coverage*–Workers at all income levels and their families have protection if earnings stop or are reduced due to retirement, disability, or death. With nearly all employment covered by Social Security, this protection continues when workers change jobs; and
- *Rights Clearly Defined in the Law*–How much a person gets and under what conditions are clearly defined in the law and are generally related to facts that can be objectively determined. The area of administrative discretion is severely limited.

Social Security Administration

The Social Security Administration (SSA) is an independent agency of the federal government which has the duty of administering the nation's social insurance programs, such as:

- Old-age, Survivors, and Disability Insurance programs commonly known as Social Security.
- Administers the Supplemental Security Income program for the aged, blind, and disabled.
- Assigns Social Security numbers to U.S. citizens; and
- Maintains earnings records for workers under their Social Security numbers.

The SSA was established by Reorganization Plan No 2 of 1946 (5 U.S.C. app.) effective July 16, 1946. It became an independent agency in the executive branch by the Social Security Independence and Program Improvements Act of 1994 (codified at 42 U.S.C. § 901) effective March 31, 1995.

The SSA is headed by a commissioner and has a staff of almost 60,000 employees. The Commissioner is responsible for administering the OASDI program (except for the collection of FICA taxes, which is performed by the Internal Revenue Service of the Department of the Treasury), the preparation and the payment of benefits through direct deposit (federal law requires federal benefit payments to be made electronically), and the management and investment of the trust funds, which is supervised by the Secretary of the Treasury as Managing Trustee. The Commissioner is appointed by the President and confirmed by the Senate for a 6-year term. On July 9, 2021, President Biden fired Commissioner Andrew Saul, a holdover from the Trump administration, after he refused to resign and was replaced with Acting Commission Dr. Kilolo Kijakazi.

A bipartisan Advisory Board, composed of seven members who serve 6-year terms, examines the Social Security system issues and advises the Commissioner on policies related to the OASDI (and SSI) programs.

The Social Security number (SSN) is used to post and maintain the earnings and employment records of persons covered under the Social Security program. By the end of February of each year, employers file wage reports (Form W-2) with the SSA showing the wages paid to each employee during the preceding year. In turn, SSA shares this information with the IRS.

Reported earnings are posted to the worker's earnings record at SSA headquarters in Baltimore, Maryland. When a worker or family member applies for Social Security benefits, their earnings record determines the claimant's eligibility and the benefit amount.

The SSA is made up of many different bureaus and branches to accomplish all its duties. The main offices are headquartered in Woodlawn, Maryland, and they are known as the Central Office. The entire United States is divided up by SSA into districts (10 districts), each of which has its own District office. Many of these District Offices also have branch offices. There are approximately 1300 field offices throughout the nation. The District Office is set up to manage all contact with the public. To view information about the nearest SSA office, visit http://www.ssa.gov. In addition, there are 8 processing centers and 37 Teleservice Centers (TSCs). The TSCs are set up to manage telephone inquiries from the public. They are designed to take the burden of voluminous phone calls away from the District Offices. The nationwide toll-free number is 1-800-772-1213. Service representatives manage calls from 7 a.m. to 7 p.m. on business days. Pre-recorded information and automated services are available after hours. Hearing-impaired callers with TDD equipment can call 1-800-325-0778.

Further Reading

The History Channel, "*Social Security*," History.com Editors (2019), https://www.history.com/topics/great-depression/social-security-act

National Academy of Social Insurance, "*Key Dates in History of Social Security,*" https://www.nasi.org/learn/socialsecurity/key-dates

Social Security Administration, The Social Security Fairness Act of 2024; Social Security Fairness Act: Windfall Elimination Provision (WEP) and Government Pension Offset (GPO) update | SSA

Congress. Gove; H.R.82 - 118th Congress (2023-2024): Social Security Fairness Act of 2023 | Congress.gov | Library of Congress

Chapter 1
Review Questions

1. In what year was the Social Security program enacted into law?

( ) A. 1929
( ) B. 1933
( ) C. 1935
( ) D. 1951

2. Which of the following U.S. Presidents signed the Social Security Act into law?

( ) A. President Lyndon B. Johnson
( ) B. President Franklin D. Roosevelt
( ) C. President Harry S. Truman
( ) D. President Dwight D. Eisenhower

3. Which of the following Social Security Amendments introduced the automatic Cost-of-Living Adjustments (COLAs)?

( ) A. 1983 Amendments
( ) B. 1965 Amendments
( ) C. 1972 Amendments
( ) D. 1977 Amendments

4. Which of the following agencies of the federal government has the duty of administering the Social Security OASDI program?

( ) A. Department of Labor
( ) B. Social Security Administration
( ) C. Department of Health and Human Services
( ) D. Department of Consumer and Financial Services

5. What is the primary purpose of the Social Security Fairness Act signed into law on January 5, 2025?

( ) A. To increase the retirement age for Social Security beneficiaries.
( ) B. To eliminate reductions in Social Security benefits for individuals receiving non-covered pensions.
( ) C. To introduce new taxes on Social Security benefits.
( ) D. To privatize the Social Security System.

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CHAPTER 2

OASDI PROGRAMS

Overview

Old-Age, Survivors, and Disability Insurance (OASDI) is a series of related programs. Each has its own rules and payment schedules. All the programs have one thing in common: Benefits are paid–to a retired or disabled worker, or the worker's dependent or surviving family–based on the worker's average wage, salary, or self-employment income from work covered by Social Security.

This chapter will examine the various types of OASDI benefit programs, their qualifications and eligibility requirements, and the funding mechanism for OASDI.

Learning Objectives

Upon completion of this chapter, you will be able to:

- Describe the various OASDI programs.
- Determine qualification for OASDI benefits.
- Calculate quarters of coverage (credits).
- Differentiate between being currently and fully insured; and
- Explain how OASDI programs are funded.

OASDI Background

The Old-Age, Survivors, and Disability Insurance (OASDI) program provides monthly benefits designed to replace, in part, the loss of income due to retirement (Old-Age–OA), death (Survivor Insurance–S), or disability (Disability–DI). Coverage is nearly universal. Overall, about 90 percent of U.S. wage earners (183 million workers) are covered by Social Security. Eligibility and benefit amounts are determined by the worker's contribution to Social Security. There is no means test to qualify for benefits, although there is a limit on income earned from working that applies to those under the full retirement age (FRA).

Types of OASDI Benefits

There are three basic Social Security (OASDI) benefit programs that pay benefits based on the worker's earnings record. They are:

- Old-Age (OA) Retirement benefits.
- Survivor benefits (S); and
- Disability benefits (DI).

According to the Social Security Beneficiary Data Report, as of May 2025, the OASDI program was providing benefit payments to 69.6 million people and totaling $1.552 trillion in benefits. Retirement benefits were paid to 55.55 million beneficiaries (79.8%) totaling $1.3 trillion in benefits, survivor benefits were paid to 5.85 million beneficiaries (8.4%) totaling $110.1 billion in benefits, disability insurance benefits were paid to 8.2 million beneficiaries (11.8%) totaling $142.1 billion in benefits (see Table 2.1).

Table 2.1
Beneficiaries in Current-Payment Status,
as of May 2025

Beneficiary	Number (thousands)	Percent
Total	**69,628**	**100%**
Old Age and Survivor Insurance	**61,405**	**88.2%**
Retired Benefits	**55,551**	**79.8%**
Retired Workers	52,817	75.9%
Spouses of Retired Workers	1,995	2.9%
Children of Retired Workers	739	1.1
Survivor Benefits	**5,854**	**8.4%**
Children of deceased workers	2,081	3.0%
Widowed mothers and fathers	99	0.1%
Nondisabled widow(er)s	3,479	5.0%
Disabled Widow(er)	196	0.3%
Parents of deceased workers	1	
Disabled Insurance	**8,223**	**11.8**
Disabled Workers	7,137	10.3%
Spouses	87	0.1%
Children	999	1.4%
Total OASDI	**69,628**	**100%**

Source: Benefits Paid By Type of Beneficiary;
https://www.ssa.gov/OACT/ProgData/icp.html

Average Benefit Amounts

The average monthly benefit for a retired worker in current payment status, as of May 2025, was $2,002.39. Benefits payable to workers who retire at full retirement age (FRA) and to disabled workers are equal to 100% of the primary insurance amount (PIA),

subject to any applicable deductions. Widow (er) benefits are also payable at 100% of the insured worker's PIA at FRA. Non-disabled widow(er)s can receive reduced benefits at age 60. Disabled widow(er)s can receive reduced benefits at age 50. Spouses, children, and parents receive a smaller proportion of the worker's PIA than widow(er)s (see Table 2.2).

Table 2.2
All Beneficiaries: Average monthly benefit by type of benefits in current-payment Status (in dollars), as of May 2025

Type of Benefit	Benefits in current-payment status, May 2025
Total	$1,857.75
Total OASI Benefits	$1,913.70
Retirement Benefits	$1,950.27
Retired workers	$2,002.39
Spouses of retired workers	$950.20
Children of retired workers	$925.14
Survivor Benefits	$1,566.66
Children of deceased workers	$1,139.18
Widowed mothers and fathers	$1,314.10
Nondisabled widow(er)s	$1,863.71
Parent of deceased worker	$1,697.90
Disability Insurance	$1,439.97
Disabled workers	$1,581.97
Spouses of disabled workers	$440.46
Children of disabled workers	$512.13

Source: Number of Social Security recipients by type of beneficiary (ssa.gov)

Beneficiaries, By Age

According to SSA Facts and Figures as of the end of December 2024 (latest data available), 59.60 million of current OA (retired workers) beneficiaries were age 62 and older, including 19.1 million in the age group of 62 - 69; 34.4 million in the age group of 70-84; and 6 million in the age group of 85 and older. Of all adults receiving OASDI, 26.7 million (44.9%) were men, and 32.9 million (55.1%) were women (see Table 2.3).

Figure 2.3
Social Security beneficiaries (Retired Workers) aged 62 and over, as of December 2024

Age Group	Total	Male		Female	
		Number	Percent	Number	Percent
62–69	19,056	8,703	45.7%	10,354	54.3%
70–84	34,436	15,732	45.7%	18,704	54.3%
85 & over	6,110	2,304	37.7%	3,806	62.3%
Total, age 62 & over	59,602	26,739	44.9%	32,863	55.1%

Note: Excludes adults who became disabled as children. Totals do not necessarily equal the sum of rounded components. Source: https://www.ssa.gov/OACT/ProgData/byage.html

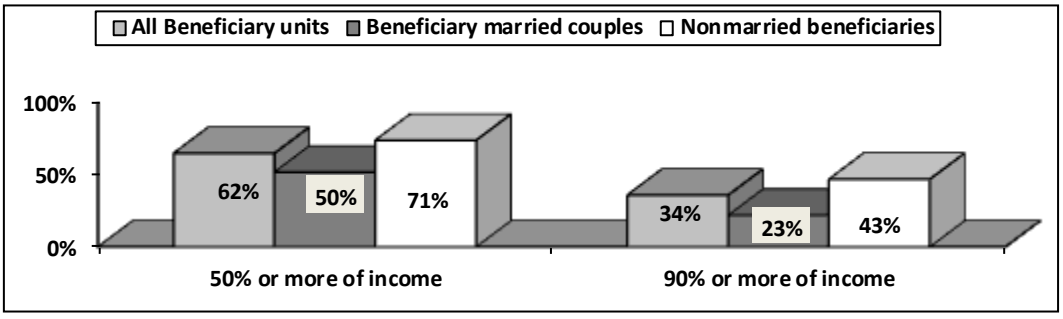
Relative Importance of OASDI

Social Security is a major source of income for most people over age 65:

- Nearly nine out of ten individuals aged 65 and older were receiving Social Security benefits, as of May 2025.
- Social Security benefits represent about 31% of the income of people over age 65.
- Among Social Security beneficiaries aged 65 and older, 39% of men and 44% of women receive 50% or more of their income from Social Security.
- Among Social Security beneficiaries aged 65 and older, 12% of men and 15% of women rely on Social Security for 90% or more of their income.

Social Security was the major source of income (providing at least 50 percent of total income) for 50 percent of aged beneficiary couples and 71 percent of aged non-married beneficiaries). It was 90 percent or more of the income for 23 percent of aged beneficiary couples and 43 percent of aged non-married beneficiaries. Total income excludes withdrawals from savings and non-annualized IRAs or 401(k) plans (see Figure 2.4).

Figure 2.4
Percentage of Aged Units Receiving Social Security Benefits



Source: SSA Fast Facts Figures About Social Security Social Security Basic Facts (ssa.gov)

Old-Age (OA) Retirement Benefits

Social Security is designed as a "*progressive*" social insurance system. It replaces a greater part of the average monthly pay for low-income workers than for high-income workers.

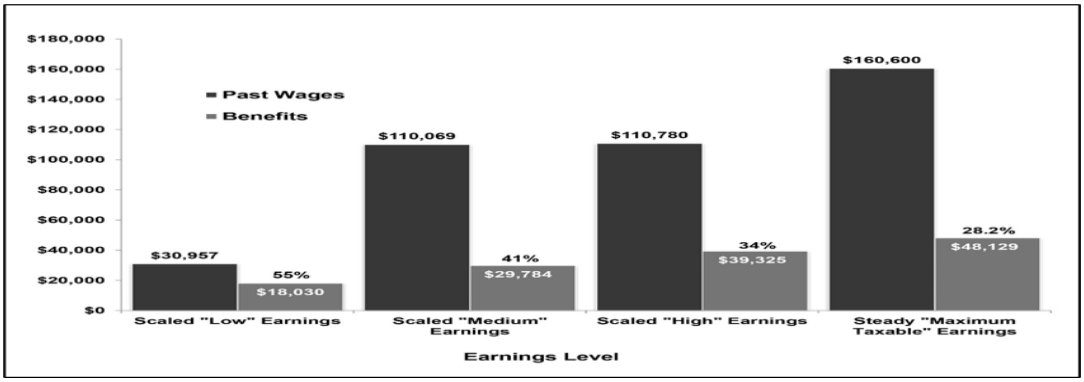
Table 2.5 displays how Old-Age retirement benefits compared to a retiree's past earnings for a "low," "medium," "high," and "maximum taxable" earner. The short bars are the benefits that a retiree would receive at age 65. The tall bars represent the retiree's typical (or average indexed) lifetime earnings while working. Old Age retirement benefits replace a larger share of past earnings for lower earners. While higher earners receive larger benefit checks, those checks represent a smaller fraction of what they made.

Figure 2.5 shows four different pre-retirement earnings patterns for a 66.10 month -year-old who retires in 2024. The first three patterns assume the earnings history of workers with scaled earnings and reflect low, medium, high, and high average levels of pre-retirement earnings starting at age 21. The fourth pattern assumes the earnings history of a steady maximum earner starting at age 22. The three scaled-earning patterns derive from earnings experience by insured workers during calendar years 2001 through 2020. These earnings levels differ by age. The career average level of earnings for each scaled case targets a percentage of the AWI.

For the scaled medium earner, the career-average earnings level is about equal to the AWI (estimated to be $68,793 for 2024). For the scaled low and high earners, the career average earnings level, wage-indexed to the year before starting benefit is about 25 percent, 45 percent, and 160 percent of the AWI, respectively (estimated to be $17,198, $30,957, and $110,069, respectively, for 2024.

Overall, the amount of retired workers' benefits will be between 28% of their average income (if their income was high) and 58% (low income).

Figure 2.5
Replacement Rates for Retired Workers Aged 66.10 months, 2024



Source: Annual Trustees Report, Social Security Administration, 2024; Table V.C7
C. PROGRAM-SPECIFIC ASSUMPTIONS AND METHODS (ssa.gov)
Note: These benefits may increase with a yearly cost of living adjustment (COLA)..

In addition, OA benefits may also be payable to the spouse and children of retired-worker beneficiaries. A spouse receives benefits at age 62 or any age if caring for a child under age 16 or disabled. A divorced spouse aged 62 or older married to the worker for at least 10 years is also entitled to benefits. If the spouse has been divorced for at least 2 years, the worker eligible for benefits need not receive benefits from the former spouse. Benefits are payable to unmarried children under the age of 18 or 18-19 if they attend elementary or secondary school full-time. A child can be the worker's natural child, adopted child, stepchild, and–under certain circumstances—a grandchild or step-grandchild. A person aged 18 or older may also receive benefits under a disability that began before age 22.

The maximum benefit for a worker reaching their FRA on/after January 2, 2025, will receive $4,018 per month, or $48,936 an increase from $3,822 per month, or $45,864 per year in 2024. Few retirees will get the 2025 maximum Social Security check of $4,018 a month. To score the maximum benefit, a worker would have to have earned the top maximum taxable income for the past 35 years. According to SSA, in 2024 there were a total of 3.7 million new retired workers, only 842K (23%) received a check that exceeded $2,700 per month, or $32,400 a year. Depending on the age elected to begin Social Security benefits, the maximum total monthly benefit or 2025 ranges from $2,831to $5,108, or $33,972 to $61,296 yearly. That's assuming the retiree had been in the highest tax bracket since they started working at age 22, so for most people, these are not realistic. The average Social Security check will be $1,976 a month, or $23,712 a year.

Note: SSA has an online calculator that estimates monthly-old-age benefits based on a worker's earnings, birth date, and expected retirement age. You can view it at: http://www.socialsecurity.gov/retire2/AnypiaApplet.html

Survivor (S) Benefits

Survivor benefits are also paid out to the families of workers who die and leave behind spouses, children under the age of 20, and sometimes other relations such as parents and ex-spouses.

A widow(er) married to the worker for at least 9 months (3 in the case of accidental death) may receive an unreduced benefit if claimed at full (normal) retirement age (currently age 66) if the spouse never received a retirement benefit reduced for age. It is permanently reduced if claimed at age 60-66 and disabled survivors aged 50-59. Benefits are payable to a widow(er) or surviving divorced spouse at any age who is caring for a child under age 16 or disabled. A surviving divorced spouse aged 60 or older is entitled to benefits if they had been married to the worker for at least 10 years. A deceased worker's dependent parent aged 62 or older may also be entitled to benefits. Surviving children of deceased workers may receive benefits if they are under age 18, full-time elementary or secondary school students aged 18-19, or disabled before age 22.

Disability Insurance (DI) Benefits

Disability insurance benefits are payable to disabled workers after a waiting period of 5 full calendar months. This rule applies because DI is not intended to cover short-term disabilities. Benefits terminate if the beneficiary medically improves and returns to work (at a substantial gainful activity level) despite the impairment. At age 65, beneficiaries are transferred to the OA retirement program. Benefits for family members of a disabled worker are payable under the same conditions as those of retired workers.

2025 Estimated Average Monthly Social Security Benefits

Table 2.6 displays the projected OASDI average benefit payments for 2025. SSA projects that the average benefit for retired workers beginning January 2, 2025, after the 2.5% COLA, will be $1,976, or about $23,712 a year. The average benefit for retired workers beginning January 2, 2025, before the 2.5% COLA, would have been $1,927, or about $23,124 a year. For comparison, the 2024-2025 federal poverty guideline (100%) is $15,060 for an individual, $20,440 annually for a couple, and $25,820 for a family of three.

Table 2.6
Estimated Average Monthly Social Security Benefits, January 2, 2025

	Before 2.5% COLA	After 2.5% COLA
All Retired workers	$1,927	$1,976
Aged couple, Both Receiving Benefits	$3,014	$3,089
Widowed Mother and Two Children	$3,669	$3,761
Aged Widow(er) Alone	$1,788	$1,832
Disabled Worker, Spouse and One or More Children	$2,757	$2,826
All Disabled Workers	$1,542	$1,580

Source: SSA Fact Sheet, 2025 Social Security Changes
https://www.ssa.gov/news/press/factsheets/colafacts2025.pdf

Qualifying for OASDI Benefits

To qualify for OASDI benefits, a worker must have worked a certain amount of time in employment covered by Social Security. According to the SSA Fact Sheet an estimated 184 million workers will work in OASDI-covered employment in 2024. In 2024, there are an estimated 2.7 covered workers per Social Security beneficiary. By 2035, the Trustees estimate there will be 2.4 covered workers for each beneficiary.

In recent years, coverage has become nearly universal for work performed in the United States, including American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. OASDI covers approximately 94 percent of the U.S. workforce. Workers excluded from coverage fall into five major categories:

- Civilian federal employees hired before January 1, 1984.
- Railroad workers (who are covered under the railroad retirement system, which is coordinated with Social Security).
- Certain employees of state and local governments who are covered under their employers' retirement systems.
- Domestic workers and farm workers whose earnings do not meet certain minimum requirements (workers in industry and commerce are covered regardless of the amount of earnings); and
- Persons with extremely low net earnings from self-employment, generally under $400 annually.

The work requirement is called "*insured status*." Insured status is also required to establish benefit eligibility for the worker's family members and/or survivors. The requirements for insured status differ depending on the type of benefits involved.

Insured Status

Workers attain insured status upon earning the minimum number of credits needed to become eligible for Social Security benefits. Insured status is also required to establish benefit eligibility for the worker's family members or survivors. The requirements for insured status differ depending on the type of benefits involved.

To determine a worker's insured status, Social Security looks at the amount of the worker's earnings (employment or self-employment) covered under Social Security. It assigns "credits" for those earnings.

Quarters of Coverage

These credits are called quarters of coverage. In 2025, one-quarter of coverage (QC) is credited for each $1,810 (up from $1,730 in 2024) in annual covered earnings, up to a maximum of four QCs for the year. Earnings of $7,240 or more in 2025 (up from $6,920 in 2024) will give the worker a maximum of four QCs for the year regardless of when the money is paid during the year. The amount of earnings required for a QC is adjusted each year automatically in proportion to increases in the average wage level.

Table 2.7 illustrates how to calculate the Quarter of Coverage amount for 2025. The law specifies that the Quarter of Coverage (QC) is equal to the 1978 amount of $250, multiplied by the ratio of the national average wage index (NAWI) for 2023 to that for 1976, or if larger, the 2024 amount of $1,730. If the amount so determined is not a multiple of $10, it shall be rounded to the nearest multiple of $10.

Table 2.7
Determination of the Quarter of Coverage Amount for 2025

Amounts in Formula	1978 earnings for one QC	$250
	1976 average wage index	9,226.48
	2022 average wage index	66,621.80
Computation	$250 x 66,621.80 divided by 9,226.48 = $1,805.18 which is rounded to $1,810	
Higher Amount	$1,730 exceeds the amount for 2024, so the earnings needed to earn one QC in 2025 is $1,810	

Source: https://www.ssa.gov/OACT/COLA/QC.htm

Quarters for Self-Employed Individuals

The method for determining QCs for self-employed individuals is different than it is for employees. Before 1978 the self-employed person received four QCs for a year if the net earnings from self-employment were $400 or more. If the net earnings from self-employment were less, the self-employed did not receive any QCs. It was all or nothing. In 1978, the rules changed. For all years following 1978, a self-employed person receives QCs based on total yearly earnings in the same way as an employee. However, the self-employed individual must still meet a minimum of $400 in net earnings from self-employment to receive any QCs.

Types of Insured Status

There are different kinds of insured status depending on the type of benefits being claimed. They are:

- Fully Insured Status.
- Currently Insured Status; and
- Disability Insured Status.

Fully Insured Status

Eligibility for most types of benefits requires that the worker be fully insured. To be fully insured, a worker must have several QCs at least equal to the number of calendar years elapsing between the year in which the worker is age 21 (or 1950, if later) and the year in which they reach age 62, becomes disabled, or dies–whichever occurs first. To compute "elapsed" years, Social Security does not count the year the worker attains age 21 (or 1950, if later) or the year in which the worker attains age 62, becomes disabled, or dies. If the resulting number of elapsed years is less than 6, the number is raised to 6. All workers need at least 6 QCs to be insured workers who reach age 62 in 1991 or later need 40 QCs to be fully insured. Special rules may apply if the worker has a prior period of disability. For workers who become disabled or die before age 62, the number of QCs needed for fully insured status depends on their age at the time of disability or death.

According to SSA, there are 227 million individuals who have accumulated enough quarters of coverage over their working life to become insured.

Currently Insured Status

A worker is currently insured if they have at least 6 QCs in the 13 quarters ending with the quarter of death or disability. Generally, if a worker dies before meeting fully insured status, benefits can still be paid to certain survivors if the worker was "*currently insured*" at the time of death. Survivor benefits are potentially payable to a worker's children and a widow(er) who takes care of the deceased's child under age 16 or disabled and receives Social Security benefits.

Disability Insured Status

To qualify for disability benefits, a non-blind worker must have recent work activity in addition to being fully insured. Under the requirement involving recent work, a non-blind worker aged 31 or older must have earned at least 20 QCs during the 40-calendar-quarters period ending with the quarter in which the disability began. In general, workers disabled at ages 24 through 30 must have earned QCs in one-half of the calendar quarters, beginning with the quarter after the quarter in which age 21 is attained and ending with the calendar quarter in which the disability began. In this case, the quarters counted will go back before the quarter in which the worker turned 21. Workers under age 24 need 6 QCs in the 12 quarters ending with the quarter in which the disability began. Workers who qualify for benefits based on blindness need only be fully insured. Special rules may apply if the worker has a prior period of disability.

According to SSA, there are 156.6 million individuals who have accumulated enough quarters of coverage over their working life to become insured in the event of disability.

Non-Citizen Workers

The Social Security Protection Act of 2004 (Public Law 108-203) was signed on March 2, 2004. Section 211 of this law imposed additional requirements for determining fully and currently insured status. These additional requirements affect noncitizen workers to whom Social Security did not assign a Social Security number (SSN) before January 1, 2004. A non-citizen worker must meet one of two additional requirements under Section 211 for anyone to qualify for an OASDI benefit based on the earnings record of the non-citizen worker. These benefits include retirement or disability insurance benefits, dependents or survivor insurance benefits, the lump sum death payment, and Medicare based on end-stage renal disease.

For purposes of the above paragraph:

- The non-citizen worker must have been assigned an SSN for work purposes at any time on or after January 1, 2004; or

- The non-citizen worker must have been admitted to the United States at any time as a non-immigrant visitor for business (B-1) or as an alien crewman (D-1 or D-2).

If a non-citizen worker who was not assigned an SSN before January 1, 2004, does not meet one of these additional requirements, they cannot be fully or currently insured. No one would qualify for OASDI benefits based on the non-citizen worker's earnings. This is true even if the non-citizen worker appears to have the required number of QCs in accordance with the regular insured status provisions.

OASDI Financing

The OASDI program is financed primarily by payroll (employment) taxes, enacted by congress in 1935 by the Federal Insurance Contributions Act (FICA), currently codified in Title 26, Subtitle C, Chapter 21, of the United States Code. These taxes are deposited in two separate trust funds–the OASI Trust Fund and the DI Trust Fund (discussed below).

Payroll Taxes

Net payroll tax contribution consisted of taxes paid by employees, employers, and the self-employed on earnings covered by Social Security. These taxes are paid on covered earnings up to a specified maximum annual amount. For 2025, the amount will be $176,100, a 4.3% increase from $168,600 in 2024 (see Table 2.8).

Table 2.8
Maximum Social Security
Contribution and Benefit Base, (1937–2025)

Year	Amount	Year	Amount	Year	Amount	Year	Amount
1937-50	$3,000	1981	29,700	1996	62,700	2011	106,800
1951-54	3,600	1982	32,400	1997	65,400	2012	110,100
1955-58	4,200	1983	35,700	1998	68,400	2013	113,700
1959-65	4,800	1984	37,800	1999	72,600	2014	117,000
1966-67	6,600	1985	39,600	2000	76,200	2015	118,500
1968-71	7,800	1986	42,000	2001	80,400	2016	118,500
1972	9,000	1987	43,800	2002	84,900	2017	127,200
1973	10,800	1988	45,000	2003	87,000	2018	128,400
1974	13,200	1989	48,000	2004	87,900	2019	132,900
1975	14,100	1990	51,300	2005	90,000	2020	137,700
1976	15,300	1991	53,400	2006	94,200	2021	$142,800
1977	16,500	1992	55,500	2007	97,500	2022	$147,000
1978	17,700	1993	57,600	2008	$102,000	2023	$160,200
1979	22,900	1994	$60,600	2009	106,800	2024	$168,600
1980	$25,900	1995	61,200	2010	106,800	2025	$176,100

According to the Social Security Facts and Figures, 94% of working Americans earn less than the maximum taxable earnings cap, meaning they're paying every dollar they earn into the program. Meanwhile, the remaining 6% of workers who earn more than the max cap ($176,100 in 2025) a year will have some or most of their earned income exempted from the payroll tax. More specifically, about 83% of earnings in covered employment were taxable in 2023, compared with 92% in 1937.

Then Congress passed, and the President signed "*The Temporary Payroll Tax Cut Continuation Act of 2011,"* which kept alive the two-percentage-point payroll tax cut (for certain taxpayers) only for January and February 2012. On February 17, 2012, Congress passed H.R. 3630, and President Obama signed the "*Middle Class Tax Relief and Job Creation Act of 2012*" that extended the two-percentage-point payroll tax cut through the end of 2012.

Note: Amounts for 1937-74 and 1979-81 were set by statute; all other amounts were determined under automatic adjustment provisions of the Social Security Act. On January 1, 2013, the payroll tax rates returned to the 6.2 percent rate (both employee and employer). For 2025, the maximum yearly withholding from a worker who earns up to the maximum wage base ($176,100) will pay a total of $10,918.20 (see Table 2.9).

Table 2.9
OASDI for Wages Paid, 1973–2025

Rate for Employees				Rate for Employer		
Year	**OASI**	**DI**	**Total**	**OASI**	**DI**	**Total**
1973	4.300	0.550	4.850	4.850	0.550	4.850
1974-77	4.375	0.575	4.950	4.950	0.575	4.950
1978	4.275	0.775	5.050	5.050	0.775	5.050
1979	4.330	0.750	5.080	5.080	0.750	5.080
1980	4.520	0.560	5.080	4.520	0.560	5.080
1981	4.700	0.650	5.350	5.350	0.650	5.350
1982	4.575	0.825	5.400	5.400	0.825	5.400
1983	4.775	0.625	5.400	4.775	0.625	5.400
1984-87	5.200	0.500	5.700	5.700	0.500	5.700
1988-89	5.530	0.530	6.060	5.700	0.530	6.060
1990-1993	5.600	0.600	6.200	6.200	0.600	6.200
1994-96	5.260	0.940	6.140	5.260	0.940	6.140
1997-99	5.350	0.900	6.250	5.350	0.850	6.250
2000-10	5.300	0.900	6.200	5.300	0.900	6.200
2011[2] -2012	3.590	0.610	4.200	5.300	0.900	6.200
2013	5.300	0.900	6.200	5.300	0.900	6.200
2014-2025	5.300	0.900	6.200	5.300	0.900	6.200

The OASDI Trust Funds, As of January 1, 2013, the employee contribution was increased to 6.2% for a total (employee and employer) OASDI tax of 12.4%.

Payroll Tax for Self-Employed

A tax like the FICA tax is imposed on the earnings of self-employed individuals, such as independent contractors and members of a partnership. This tax is imposed not by FICA but instead by the Self-Employment Contributions Act (SECA) of 1954, which is codified as Chapter 2 of Subtitle A of the Internal Revenue Code, 26 U.S.C. § 1401 through 26 U.S.C. § 1403 (the "SE Tax Act").

Under the SE-Tax Act, self-employed people are responsible for both the employees (6.2%), the employer (6.2%), for a total of 12.4%. The self-employed individual is also responsible for 2.9% of Medicare taxes, creating a total tax responsibility of 15.3%. However, the 15.3% multiplier is applied to 92.35% of the business's *net earnings from self-employment* rather than 100% of the gross earnings. The difference of 7.65% is half of the 15.3%. It makes the calculation fair in comparison to that of regular (non-self-employed) employees.

It does this by adjusting that the employee's 7.65% share of their SE tax is multiplied against a number (their gross income) that does not include the putative "employer's half" of the self-employment tax. In other words, it makes the calculation fair because employees don't get taxed on their employers' contribution of the second half of FICA. Therefore, self-employed people shouldn't get taxed on the second half of the self-employment tax. Similarly, self-employed people also deduct half of their self-employment tax (Schedule SE) from their gross income on the way to arriving at their adjusted gross income (AGI). This levels the amount paid by self-employed people compared to regular employees, who don't pay general income tax on their employer's contribution of the second half of FICA, just as they didn't pay FICA tax on it either.

Exemption for Certain Full-Time Students

A special case in FICA regulations includes exemptions for student workers. Students enrolled at least half-time in a university and working part-time for the same university are exempted from FICA payroll taxes, so long as their relationship with the university is primarily an educational one. Medical residents working full-time are not considered students and are not exempt from FICA payroll taxes.

Social Security Trust Funds

Social Security's financial operations are managed through two federal trust funds:

- The Old-Age and Survivors Insurance (OASI) Trust Fund; and
- The Disability Insurance (DI) Trust Fund.

Although legally distinct, they are often referred to collectively as "*the Social Security Trust Fund*." Social Security's payroll taxes and other earmarked income are deposited in the trust funds. All Social Security benefits and administrative expenses are paid from trust funds.

Social Security is largely a "*pay as you go*" program, meaning today's benefits are funded primarily by the payroll taxes collected from today's workers. According to the 2025 Social Security OASDI Trustees report, for 2024, total income, including interest, to the combined OASDI Trust Funds amounted to $1,417.8 trillion, which consisted of $1,293.3 trillion in net payroll tax contributions (91%), $55.1. billion from taxation of benefits (4%), and $69.1 billion in interest earnings (5%). Total costs for the OASDI program in the calendar year 2024 were $1,484.8 trillion paid to nearly 68 million beneficiaries. Total benefit payments to OASI beneficiaries were $1,316.4 (89%) and $155 billion to DI beneficiaries (11%). The total cost to administer the OASDI program in calendar 2024 was $7.4 billion (6%). Total payments for Railroad Retirement were $5.9 billion (4%). Asset reserves held in special issue U.S. Treasury securities decreased from $2,788.5 trillion as of December 2023 to $2,721.5 trillion at the end of the year (see Table 2.10).

Table 2.10
Trust Fund Financial Operations, In 2024
(In billions)

	OASI	DI	OASDI
Asset reserves as of December 31, 2023	$2,641.5	$147.0	$2,788.5
Total Income in 2024	1,224.0	193.8	1,417.8
Net payroll tax contributions	1,105.6	187.7	1,293.3
Taxation of benefits	54.4	.7	55.1
Interest and Investments	63.7	5.4	69.1
Total Cost in 2024	1,327.2	157.6	1,484.8
Benefit payments	1,316.4	155.0	1,471.4
RR financial interchange	5.9	.1	5.9
Administrative expenses	4.9	2.5	7.4
Net increase in asset reserves in 2024	-103.2	36.2	-67.0
Assets at the end of 2024	2,538.3	183.2	2,721.5

Source: 2024 Social Security Trustees Report, Table II.B1
https://www.ssa.gov/OACT/TR/2025/II_B_cyoper.html

For the first time, beginning in 2018, Social Security began redeeming those asset reserves to help pay benefits. Payroll taxes from current workers will continue to pay for the bulk of benefits. The trust fund reserves will make up the difference between income and costs until the reserves are depleted (see Chapter 9 for a full discussion of the financial status of the Social Security Trust Funds). At that point, Social Security's income will still be able to pay three-quarters of promised benefits–even in the unlikely event that policymakers fail to act.

How Trust Funds Are Invested

The Social Security trust funds are invested entirely in U.S. Treasury securities. Like the Treasury bills, notes, and bonds purchased by private investors around the world, the Treasury securities that the trust funds hold are backed by the full faith and credit of the

U.S. government. The U.S. government has *never* defaulted on its obligations, and investors consider U.S. government securities one of the world's safest investments.

By the end of 2024, the combined trust fund reserves had accumulated nearly $2,721.305 trillion worth of Treasury securities, earning an average interest rate at an effective annual rate of 2.5 percent during that year. The Social Security Administration (SSA) provides monthly reports on the investment holdings of the trust funds, their maturities, and interest rates. The 2025 Trustees Report reports that the OASDI Trust Fund earned $69.1 billion in interest income in 2024.

Retirement, survivor, and disability benefits accounted for 99.1 percent of OASI and DI combined trust fund costs in 2024. The expenses for administering the Social Security program were 0.5 percent of the total cost. The net payment to the Railroad Retirement Social Security Equivalent Benefit Account from the combined OASI and DI Trust Funds accounted for 0.4 percent of total OASDI cost.

Trust fund reserves provide the basis for paying benefits. Combined trust fund reserves decreased by $67 billion during 2024 because the income to the combined funds, including interest earned on trust fund reserves, was less than the total cost. In last year's Trustees' report, combined reserves were projected to decrease by $100.4 billion in 2024. At the end of 2024, the combined reserves of the OASI and the DI Trust Funds were $2,721.5 billion, or 169 percent of the estimated cost for 2025. In comparison, the combined reserves at the end of 2023 were 188 percent of the actual cost for 2024.

By law, income from the trust funds must be invested daily in securities guaranteed as to both principal and interest by the federal government. All securities held by the trust funds are "special issues" of the United States Treasury. Such securities are available only to the trust funds.

According to Section 201(d) of the Social Security Act

> *"Each obligation issued for purchase by the Trust Funds shall be evidenced by a bond, note, or certificate of indebtedness setting forth the principal amount, date of maturity, and interest rate of the obligation and stating on its face that the obligation shall be supported by the full faith and credit of the United States and that the United States is pledged to the payment of the obligation with respect to both principal and interest."*

In the past, trust funds have held marketable Treasury securities available to the public. Unlike marketable securities, special issues can be redeemed at any time at *face value*. Marketable securities are subject to the forces of the open market. They may suffer a loss or enjoy a gain if sold before maturity. Investment in special issues gives trust funds the same flexibility as holding cash.

You can view data on trust fund investments by visiting: https://www.ssa.gov/cgi-bin/investheld.cgi

Raid or Misuse of Funds

Some critics have suggested that lending trust fund reserves to the Treasury is a misuse of those funds. This view reflects a misunderstanding of how the Treasury manages the federal government's finances.

When the rest of the budget is in deficit, a Social Security cash surplus allows the government to borrow less from the public to finance the deficit. The "public" encompasses all lenders other than federal trust funds, including U.S. individuals and institutions, the Federal Reserve System, and foreign investors. The Treasury always uses whatever cash is on hand–whether from Social Security contributions or other earmarked or non-earmarked sources to meet its current obligations before engaging in additional borrowing from the public. There is no sensible alternative to this practice. After all, why should the Treasury borrow funds when it has cash in the till?

Money that the federal government borrows, whether from investors or Social Security, is used to finance the ongoing operations of the government in the same way that money deposited in a bank is used to finance spending by consumers and businesses. In neither case does this represent a "raid" or misuse of the funds. The bank depositor will get their money back when needed, and so will the Social Security trust funds.

Further Reading

Social Security Administration, the 2025 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds," released June 18, 2025. https://www.ssa.gov/OACT/ProgData/icp.html

Social Security Administration, "Fast Facts & Figures About Social Security, 2025," Social Security Changes - COLA Fact Sheet

Social Security Administration, Social Security beneficiaries by benefit level, as of June 2024; https://www.ssa.gov/OACT/ProgData/benefitlevel.html?type=rc

Social Security Administration, "Workers Insured for Social Security Benefits, 1940-2024, as of December 31, 2024; https://www.ssa.gov/OACT/STATS/table4c1.html

Chapter 2
Review Questions

1. According to the Social Security Administration (SSA), what will be the average monthly Social Security benefit for a retired worker after the 2.5% COLA increase on January 2, 2025?

( ) A. $1,976
( ) B. $733
( ) C. $2,633
( ) D. $4,585

2. According to the 2025 Social Security Trustees Report, how many workers worked in OASDI covered employment in 2024?

( ) A. 68 million
( ) B. 51 million
( ) C. 184 million
( ) D. 225 million

3. A worker requires how many quarters (credits) of coverage to be fully insured?

( ) A. 6
( ) B. 13
( ) C. 24
( ) D. 40

4. For 2025, what percentage of the payroll tax rate must be paid separately by employees and employers?

( ) A. 3.8%
( ) B. 6.2%
( ) C. 0.9%
( ) D. 12.8%

5. How are the Social Security Trust Funds invested?

( ) A. Corporate Bonds
( ) B. Stocks
( ) C. Real Estate
( ) D. U.S. Treasury securities

CHAPTER 3

CALCULATING OLD AGE RETIREMENT BENEFITS

Overview

The Social Security program is a cornerstone of retirement planning in the United States. For financial professionals, understanding how Old Age (OA) Retirement Benefits are calculated is critical in helping clients optimize their retirement strategy.

This chapter will walk through the key steps in determining Social Security benefits, covering work history, wage indexing, the calculation of the Average Indexed Monthly Earnings (AIME), and the Primary Insurance Amount (PIA). The chapter will also explore the cost-of-living adjustments (COLA) that help maintain the purchasing power of benefits over time, some proposal changes possibly to the Chained CPI-U, and the recent changes regarding the Social Security Wage Statements.

Learning Objectives

Upon completion of this chapter, you will be able to:

- Analyze a client's work history to determine eligibility and calculate Social Security Old-Age (OA) retirement benefits.
- Calculate the Average Index Monthly Earnings (AIME) and Primary Insurance Amount (PIA).
- Explain the impact of Full Retirement Age (FRA) on benefit calculations.
- Assess the impact of early and delayed retirement benefit adjustments.
- Apply the Social Security earnings test and delayed retirement credit rules; and
- Describe how to interpret and use the Social Security Wage Statement.

Calculate Old-Age (OA) Retirement Benefits

The Social Security Administration (SSA) plays a pivotal role in providing financial security for millions of Americans, particularly in their retirement years. Old Age (OA) retirement benefits are a significant component of the Social Security system. Understanding how these benefits are calculated is critical for individuals planning for retirement, as well as for financial professionals advising clients. The calculation of OA benefits involves several key steps:

- Determining a worker's eligibility,

- Index the workers' earnings history—Wage Indexing
- Calculating their Average Indexed Monthly Earnings (AIME), and
- Computing the Primary Insurance Amount (PIA).

Determining A Workers Eligibility

The first step in calculating Social Security retirement benefits is determining whether the individual is eligible to receive benefits. As was discussed in Chapter 2, a worker qualified for Social Security if they have accumulated at least 40 quarters of coverage over their working life, which is equivalent to 10 years of covered employment. A quarter is defined as earnings a specified minimum amount ($1,810 in 2025) during a calendar year.

> ***For Example:*** Mary worked for 40 years and contributed to Social Security throughout her career. Since she has well over 40 quarters of coverage, she is eligible to receive Social Security benefits upon reaching retirement age

Wage Indexing

When SSA calculates a person's retirement benefit, they use the national average wage indexing series to index that person's earnings. Such indexing ensures that a worker's future benefits reflect the general rise in the standard of living that occurred during his or her working lifetime.

The "*wage index*" method is based on "indexed" earnings over a fixed number of years after 1951 (we will be using wages from 1983 for our computation for a worker retiring in 2025). This indexing is a mechanism for expressing prior years' earnings regarding an individual's current dollar value.

When indexing an individual's earnings for benefit computation purposes, SSA must first determine the year of first eligibility for benefits. For OA retirement, eligibility is at age 62. If a person reaches age 62 in 2025, for example, then 2025 is the person's year of eligibility. SSA will always index an individual's earnings to the average wage level two years prior to the year of first eligibility. Thus, for a person retiring at age 62 in 2025, SSA would index the worker's earnings to the average wage index for 2023, or 63,795.13. SSA would multiply earnings in a year before 2023 by the ratio of 63,795.13 to the average wage index for that year; SSA would take earnings in 2023 or later at face value.

To determine the national average wage index for calendar year 2023, SSA multiplied the 2022 national average wage index of 63,795.13 by the percentage change in average wages from 2022 to 2023, as measured by annual wage data. The wage data are based on wages subject to Federal income taxes and contributions to deferred compensation plans.

The average amounts of wages calculated directly from SSA data were $61,220.07 and $63,932.64 for 2022 and 2023, respectively. To determine the national average wage index for 2023 at a level that is consistent with the national average wage indexing series

for prior years, SSA multiplies the 2022 national average wage index of 63,795.13 by the percentage change in average wages from 2022 to 2023 (based on tabulated wage data). In other words, the national average wage index for 2022 is 63,795.13 times 63,932.64 divided by 61,220.07, which equals 66,621.80.

The complete average wage indexing series is shown in Table 3.1 below.

Table 3.1
National Average Wage Indexing Series (1951–2022)

Year	Index	Year	Index	Year	Index
1951	2,799.16	1977	9,779.44	2003	34,064.95
1952	2,973.32	1978	10,556.03	2004	35,648.55
1953	3,139.44	1979	11,479.46	2005	36,952.94
1954	3,155.64	1980	12,513.46	2006	38,651.41
1955	3,301.44	1981	13,773.10	2007	40,405.48
1956	3,532.36	1982	14,531.34	2008	41,334.97
1957	3,641.72	1983	15,239.24	2009	40,711.61
1958	3,673.80	1984	16,135.07	2010	41,673.83
1959	3,855.80	1985	16,822.51	2011	42,979.61
1960	4,007.12	1986	17,321.82	2012	44,321.67
1961	4,086.76	1987	18,426.51	2013	44,888.16
1962	4,291.40	1988	19,334.04	2014	46,481.52
1963	4,396.64	1989	20,099.55	2015	48,098.63
1964	4,576.32	1990	21,027.98	2016	48,642.15
1965	4,658.72	1991	21,811.60	2017	50,321.89
1966	4,938.36	1992	22,935.42	2018	52,145.80
1967	5,213.44	1993	23,132.67	2019	54,099.99
1968	5,571.76	1994	23,753.53	2020	55,628.60
1969	5,893.76	1995	24,705.66	2021	60,575.07
1970	6,186.24	1996	25,913.90	2022	63,795.13
1971	6,497.08	1997	27,426.00	2023	66,621.80
1972	7,133.80	1998	28,861.44		
1973	7,508.16	1999	30,469.84		
1974	8,030.76	2000	32,154.82		
1975	8,630.92	2001	32,921.92		
1976	9,226.48	2002	33,252.09		

Source: https://www.ssa.gov/OACT/COLA/AWI.html#Series

Calculating the Average Index Monthly Earnings (AIME)

As was discussed above, because of wage inflation, SSA indexes wages so that each of those 35 years of earnings is adjusted (or indexed) to reflect the change in general wage levels that occurred during the worker's years of employment. In fact, it is the indexed earnings that are ranked when choosing the 35-highest earning years.

After indexing, the SSA selects the worker's 35 highest-earning years. If a worker has less than 35 years of covered earnings, the SSA will include zeros for the remaining years

to bring the total to 35. The indexed earnings from these years are then averaged and divided by 420 months (35 years x 12 months) to obtain the worker's AIME.

> ***For Example:*** Mary's indexed earnings over her highest 35 years total $1,890,000. To calculate her AIME, SSA divides this figure by 420, resulting in an AIME of $4,500.

The final step in calculating OA retirement benefit is to use the average indexed earnings monthly earnings (AIME) amount to compute the worker's primary insurance amount (PIA), which is the actual benefit they will receive at their normal (full) retirement age (FRA).

Calculating the Primary Insurance Amount (PIA)

Social Security is designed as a "*progressive*" social insurance system, which means it replaces a greater part of the average monthly pay for low-income workers than for high-income workers. The PIA represents the monthly benefit a worker would receive at Full Retirement Age (FRA), which is 67 for individuals born in 1960 or later. The PIA is calculated using a "progressive" formula that applies different percentage rates, known as bend points, to portions of the AIME.

The bend points implement this skew relative to each worker's average indexed monthly earnings (AIME). The PIA is the sum of three separate percentages of portions of average indexed monthly earnings. The portions depend on the year in which a worker:

- Attains age 62.
- Becomes disabled before age 62; or
- Dies before attaining age 62.

The formula for the Primary Insurance Amount (PIA) is the basic benefit formula (see Table 3.2). The dollar amounts in the formula are sometimes called "*bend points*" because a formula when graphed, appears as a series of line segments joined at these amounts:

Table 3.2
Dollar Amount in PIA, 2011–2025

Year	Dollar Amounts in PIA Formula	
	First	Second
2011	$749	$4,517
2012	$767	$4,624
2013	$791	$4,768
2014	$816	$4,917
2015	$826	$4,980
2016	$856	$5,157
2017	$885	$5,336
2018	$896	$5,399
2019	$926	$5,583
2020	$960	$5,785
2021	$996	$6,002
2022	$1,024	$6,172
2023	$1,115	$6,721
2024	$1.174	$7.078
2025	$1,226	$7,391

Source: http://www.ssa.gov/OACT/COLA/bendpoints.html

For 2025 these portions are the first $1,226, the amount between $1,226 and $7.391, and the amount over $7,391. These dollar amounts are the "*bend points*" of the 2025 PIA formula (see Table 3.3).

Table 3.3
Determination of the PIA Bend Points, 2025

	Average Wage Indices	Bend Points for 1979
Amounts in Formula	For 1977: 9,779.44 For 2023: 66,621.80	First: $180 Second: $1,085
Computation of Bend Points for 2025	First Bend Point: $180 X 66,621.80 ÷ 9,779.44 = $1,226.24 which rounds to **$1,226**	Second Bend Point: $1,085 X 66,621.80 ÷ 9,779.44 = $7,391.44, which rounds to **$7,391**

Source: www.socialsecurity.gov/oact/cola/piaformula.html/

Workers With Maximum Taxable Earnings

The amount of a person's retirement benefit depends primarily on their lifetime earnings. In the examples below, SSA indexes such earnings (that is, convert past earnings to approximately their equivalent values near the time of the worker's retirement) using the national average wage index.

The examples below assume retirement in January 2025, with maximum taxable earnings since age 22. Benefits in 2025 reflect subsequent automatic benefit increases (if any). Retirement at age 70 produces the highest ratio of retirement benefit to AIME.

> ***For Example:*** Worker A, who had steady earnings at the maximum-taxable earnings in each year since age 22 and who elects to receive benefits at age 62 in January 2025, would have an AIME equal to $13,689. Based on this AIME amount and the bend points of $1,226 and $7,391, the PIA would equal $4,020.90. Because Worker A elected to receive benefits at the earliest possible age (age 62) and because worker A's normal retirement age is 67 years, the benefit amount is reduced for 60 months of early retirement. The $4,020.90 PIA is thus reduced to a monthly benefit of $2,831.
>
> ***For Example:*** Worker B, who had steady earnings at the maximum-taxable earnings in each year since age 22, and who elects to receive benefits at FRA (age 67, is not reduced for rounding down to the next lower dollar. The PIA Amount would be $4,043 per month.
>
> ***For Example:*** Worker C, who had steady earnings at the maximum taxable earnings in each year since age 22, and who elects to receive benefits at age 70, would have an AIME of $10,367, and their PIA would be $5,108 per month, due to delayed retirement credits (DRC).

Full Retirement Age

If a worker was born between 1943 and 1954, they are eligible for their full old age (retirement benefit), which is 100% of their PIA at their 66th birthday, known as their full (normal) retirement age. We will use the acronym FRA throughout the book to describe the full (normal) retirement age.

The 1983 Social Security Amendments gradually increased the normal retirement age for those born in 1960 and later to age 67. Table 3.4 shows the FRA depending on the worker's birth year to determine their FRA.

Table 3.4
Full (Normal) Retirement Age (FRA)

Year of Birth	Full (Normal) Retirement Age
1943–1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960	67

Adjustments to the PIA

Now that you understand how to calculate a worker's PIA, you must understand the rules in how a worker's PIA may be decreased or increased. In other words, if they will be receiving a lesser or a higher benefit (PIA).

Let's first review what will happen if the worker elects to receive their retirement benefits prior to FRA.

Electing Early Retirement Benefits

A fully insured worker can start receiving old-age retirement benefits the month after they reach age 62 (or the month they reach age 62 if their birthday is on the first or second of the month) or for any month thereafter. That is when most Americans opt to elect to start receiving their old-age retirement benefits at the earliest possible retirement age.

According to SSA, the number of new retired workers in 2024 was 3.713 million. Fifty-one percent were men (1.874 million), and forty-nine percent (1.830 million) were women. Of those who claimed benefits with a reduction for early retirement (at age 62) were 22.0 percent men and 23.3 percent women. The average age to elect benefits was age 65.2 for both men and women (see Figure 3.5).

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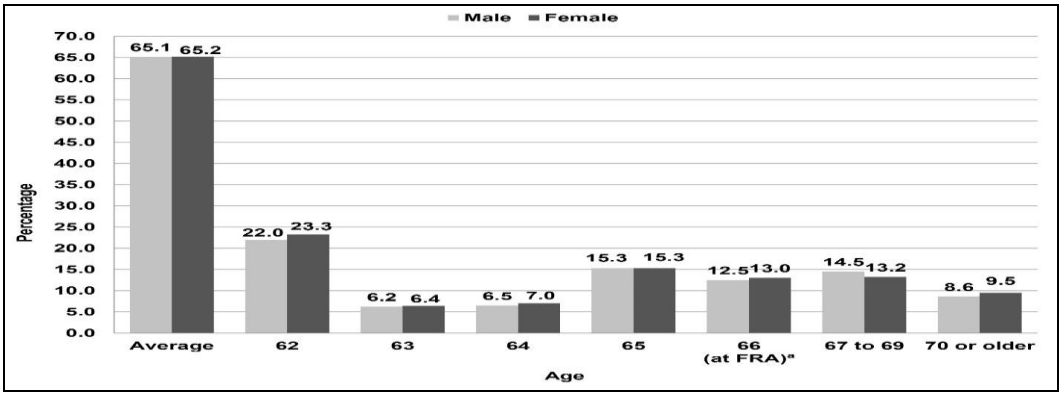
Figure 3.5
Percentage Distribution of Non-disabled Retired-Worker Benefit Awards by Age of Claimant: By Sex, 2024



Source: SSA Statistical Supplement, 2025 Trustees Report. OASDI Benefits Award Table 6.B5.1 and 2. https://www.ssa.gov/policy/docs/statcomps/supplement/2025/6b.pdf

Although most people still claim before reaching FRA, increasing proportions have been claimed later in recent years. The 22.0 percent of non-disabled men who claimed benefits at age 62 in 2024 represent a 44 percent decline from the 50.3 percent who did so in 2004. Over the same span, the percentage of men who claimed at FRA rose from 11.5 percent in 2004 to 14.5 percent in 2024, and the percentage of men who claimed at age 70 and older increased from 0.7 percent in 2004 to 8.6 percent in 2024. Similarly, the

percentage of women who claimed benefits at age 62 declined from 55 percent in 2004 to 23.3 percent in 2024. The percentage of women who claimed at FRA rose from 7.5 percent in 2004 to 13.0 percent in 2024. The percentage who claimed at age 70 and older increased from 0.7 percent in 2004 to 9.5 percent in 2024.

Electing to receive old-age retirement benefits early (prior to FRA) could be a costly mistake. For example, if a worker born between 1943 through 1954 elected to receive benefits at age 62, it meant a 25% reduction in the amount they received compared to waiting until age 66 (see Table 3.6). It is also particularly important to remember that this reduction in benefits (PIA) is permanent. The reduction factor goes by month, not by year. If a worker's first month of entitlement is six months before their FRA, their benefit (PIA) will be reduced six months and so forth back to age 62. To calculate, it would equal 5/9th of 1 percent (1/180) for each of the first 36 months under full retirement age when benefits commence and by 5/12 of 1 percent (1/240) for each month over 36.

> ***For Example**:* If a worker's PIA is $1,000, and they elect to retire and start receiving benefits 24 months before full retirement age, the benefit will be reduced by $133.40 (24 x 1/180 x $1,000), giving them a monthly benefit of $866.60.

Table 3.6
Effect of Electing Early Retirement Benefits

Year of Birth	FRA	Benefit, as a percentage of PIA, beginning at age…				
		62	63	64	65	66
1943–1954	66	75	80	86 ⅔	93⅓	100
1955	66 and 2 months	74½	79 1/6	85 5/9	92 2/9	98 8/9
1956	66 and 4 months	73½	78⅓	84 4/9	91 1/9	97 7/9
1957	66 and 6 months	72½	77 ½	83⅓	90	96⅔
1958	66 and 8 months	71½	76⅔	82 2/9	88 8/9	95 5/9
1959	66 and 10 months	70½	75 5/6	81 1/9	87 7/9	94 4/9
1960+	67	70	75	80	86½	93½

If not an even multiple of 10 cents, the reduction is increased to the next higher multiple of 10 cents.

Note: For a worker born in 1960+, the FRA is 67; the reduction in benefits at age 62 would be 30 percent.

The Retirement Earnings Test (RET)

Under the Social Security Retirement Earnings Test (RET), the monthly benefits of most Social Security beneficiaries below full retirement age (FRA)—between 65 and 67, depending on the year of birth—are reduced if they have earnings that exceed an annual threshold.

In 2025, a beneficiary below FRA and will not attain FRA during the year is subject to a $1 reduction in benefits for every $2 of earnings above $23,400 a year (increased from $22,320 in 2024). A beneficiary who will attain FRA in 2025 is subject to a $1 reduction in benefits for every $3 of earnings above $62,160 a year (increased from $59,520 in 2024). The annual thresholds are typically adjusted each year according to national average wage growth.

If a beneficiary is affected by the RET, their monthly benefit may be reduced, in part or in full, depending on the total applicable reduction. For example, if the total applicable reduction is greater than the beneficiary's monthly benefit amount, no monthly benefit is payable for one or more months. If family members also receive auxiliary benefits based on the beneficiary's work record, the reduction is prorated and applied to all benefits payable on that work record (including benefits paid to spouses who are above FRA). The RET does not apply to Social Security disability beneficiaries, which are subject to separate limitations on earnings.

The RET has been part of the Social Security program, in some form, throughout the program's history. The original rationale for the RET was that, as a social insurance system, Social Security protects workers from certain risks, including the loss of earnings due to retirement. Therefore, benefits should not be paid to workers who demonstrate, through their level of earnings, that they have not "retired." However, that rationale has changed, in part, over time. Specifically, in 2000, the RET was eliminated for those above FRA (it previously affected those above FRA until age 70).

Studies have shown that the RET has significant impacts on individuals' earnings levels via their hours worked. Specifically, evidence shows the "*bunching*" of individual earnings around the RET threshold levels. However, research has not drawn a clear conclusion on the impact of the RET on the overall labor force participation rate. Research indicates a repeal would have different impacts across the wage spectrum when considering a repeal of the RET. Specifically, it would likely incentivize the highest earners—whose entire benefits were withheld due to the RET—to decrease work, receive full benefits, and experience an increased income level overall. Research also suggests that a repeal of the RET would lead to earlier benefit-claiming and increased poverty rates, especially among women and those aged 80-89.

The Social Security Administration's (SSA) Office of the Chief Actuary (OCACT) estimated that, over the long-range projection period (2019-2093), the elimination of the RET would have a relatively small positive effect on the solvency of the Social Security Trust Funds. This is primarily because the increases in permanent early retirement

reductions for entitlement at age 62 are projected to outweigh the increases in benefit entitlements.

Retirement Earnings Test's Basics

Although legislative changes have altered various features of the RET, three key factors remain to establish the RET applicability to a worker beneficiary (and, therefore, their auxiliary beneficiaries):

- *Type of beneficiary:* The RET applies only to beneficiaries whose entitlement is not based on a disability. In other words, the RET does not apply to Social Security disabled beneficiaries, including disabled workers, disabled widow(er)s, and disabled adult children.
- *Being below FRA:* The RET can apply to any nondisabled beneficiary below the FRA, which varies between 65 and 67 depending on the year of birth (see Table 3.4). The RET does not apply to worker beneficiaries at or above FRA (application of the RET ends with the month of FRA attainment). In 2000, legislative changes made RET applicable only for beneficiaries below FRA; previously, RET applied to beneficiaries until they reached age 70.
- *Have earnings above certain thresholds in a year with entitlement to Social Security benefits*. A final applicability test requires the beneficiary to exceed an earnings threshold for any beneficiary below FRA who may be subject to the RET. The RET applies only to wage and salary income (i.e., earnings from work). It does not apply to income from pensions, rents, dividends, interest, and other "unearned" income types. A beneficiary with no earnings is not subject to the RET.

After establishing that a worker beneficiary is of the appropriate type and age and has earnings, a beneficiary must compare their annual earnings to the annual RET thresholds ($23,400 / $62,160 in 2025). The RET exempt amounts generally increase each year at the same rate as average wages in the national economy.

How the RET Works

For those beneficiaries that meet the applicable RET conditions—being nondisabled, younger than FRA, and having earnings at least above the threshold amount ($23,400 in 2025)—the RET reduces Social Security benefits. This reduction occurs in addition to early retirement actuarial reductions. When administering the RET, two important considerations are the payment of partial benefits and the grace year provision.

For beneficiaries below FRA and who will not attain FRA during the calendar year, Social Security benefits are reduced by $1 for every $2 earned above the threshold amount ($23,400 in 2025). For beneficiaries below FRA and who will attain FRA during the calendar year, Social Security benefits are reduced by $1 for every $3 earned above the threshold amount ($62,160 in 2025). Each year, beneficiaries report predicted earnings for the upcoming year (as they are not verified until the close of the taxable year). Predicted annual earnings above the exempt amount are charged against monthly

benefits, beginning with the first chargeable month of the year, at the applicable rate of $1 for every $2 or $3 of earnings above the exempt amount, and continue to be charged each month until all earnings above the exempt amount have been charged against the worker's benefits and any benefits payable to family members on their work record. A partial benefit is recorded to be paid when the charge for a given month is less than the monthly benefit.

According to the SSA procedure, when partial monthly benefits are anticipated to be paid based on projected earnings, those partial monthly benefits are paid only at the close of the taxable year. In essence, the beneficiary must wait until the statement of earnings has been verified, which usually occurs in the first quarter of the following calendar year during tax season. Despite this delay, there is no interest paid for the withheld partial benefits.

The SSA decides to wait for annual earnings statements to become finalized and validated by electing to pay beneficiaries in the next calendar year. Essentially, this is done to ensure that actual earnings for the year are equal to the predicted or reported earnings from the beginning of the year. If the actual earnings are equal to the predicted earnings, the partial benefit is paid as originally calculated. If the actual earnings are higher, however, a larger RET reduction may be warranted, which would come from the unpaid partial benefit month. In some cases, the partial benefit could be reduced to zero if actual earnings for the year exceeded the predicted earnings by a significant amount. Had the partial benefit been paid, the beneficiary would owe the SSA for benefit overpayment. If the opposite occurred and actual earnings were lower than predicted, the SSA would owe the beneficiary an additional amount above the unpaid partial benefit.

After the partial monthly benefit is withheld, the beneficiary receives full benefits for the remainder of the year. In Table 3.7, for example, the first individual (the beneficiary below FRA throughout the calendar year) receives no monthly benefits from January through July due to the RET. Then they are due a partial benefit in August. This partial monthly benefit due in August will be paid at the end of the taxable year. The monthly benefits due for the remainder of the year (September through December) are projected to be paid in full on their regular payment schedule.

In either case, it is administratively simpler to add or deduct additional benefits to or from an outstanding partial benefit payment than to issue an entirely new payment or to request repayment through collections. The intent of this procedure is twofold: administrative simplicity and to save a beneficiary the inconvenience of having to return an overpayment of benefits.

Note: If workers elect to claim Social Security benefits before their FRA, they are subject to a permanent actuarial reduction in the PIA (see Table 3.6). In the initial benefit computation, retirement benefits are reduced for early retirement by a fraction of the worker's PIA for each month of entitlement before FRA. The RET is applied to the PIA only after the early retirement actuarial adjustment has reduced it. Both the permanent reduction for early retirement and the RET are applied to beneficiaries below FRA.

Under the Grace Year Provision, a "grace year" generally applies during the first year of benefit entitlement. During the grace year, the RET is applied effectively monthly. A beneficiary may receive full benefits for any month during which their earnings do not exceed one-twelfth of the annual exempt amount, regardless of the total amount of earnings for the year. However, after becoming entitled, the monthly earnings test is an absolute one. If exceeding the monthly threshold, the beneficiary will receive no benefits for that month. In general, the grace year provision ensures that beneficiaries electing entitlement in a calendar year do not receive a withholding of their benefits after they have terminated working, at least from the pre-retirement level.

Examples of How RET Works

Table 3.7 illustrates the application of the RET to a single person who receives benefits based on their work record. The table illustrates the effect of the RET on single-worker beneficiaries in two different age groups: beneficiaries who will remain below FRA throughout the calendar year and beneficiaries who will attain FRA during the calendar year. Following Table 3.7, the two single-worker beneficiaries in the following examples experience the effects of the RET:

- Single Worker Beneficiary Who Is Below FRA: Throughout the Calendar Year This example shows a worker beneficiary with a monthly benefit amount of $2,000 (after the reduction for early retirement) and earnings of $57,280 in 2025. Because this worker beneficiary is below FRA throughout the calendar year, they are subject to a $1 reduction in benefits for every $2 of earnings above the annual exempt amount of $23,400 in 2025. Therefore, the worker has excess earnings equal to $33,880 and will have a RET reduction (a RET charge) equal to $16,940. Each month, the original monthly benefit ($2,000) is withdrawn from the RET charge, so, for this beneficiary, there will be seven months of entirely withheld benefits, one partially withheld month of benefits in August, and four months of full benefits paid.
- Single Worker Beneficiary Who Attains FRA in September of This Calendar Year: This example shows a worker beneficiary with a monthly benefit amount of $2,000 (after the reduction for early retirement) and earnings of $63,640 in 2025. Because this worker beneficiary will attain FRA during September of this calendar year, they are subject to a $1 reduction in benefits for every $3 of earnings above the annual exempt amount of $62,160 in 2025. Therefore, the worker has excess earnings equal to $1,480 and will have a RET reduction (a RET charge) equal to $493. For this beneficiary, there will only be one partially withheld month (January, wherein the RET charge is $0) with full benefits paid for the remainder of the year. As they are attaining FRA in September, the monthly benefit in September and beyond will be higher than $2,000 as it is readjusted for all of the months since entitlement that the beneficiary had benefits withheld, in part or in full, due to the RET.

Table 3.7
Hypothetical Example of the Application of the RET to a Single Worker Beneficiary with Earnings Above the Annual Exempt Amount in 2025

Step	Worker Beneficiary is Below FRA Throughout the Calendar Year	Worker Beneficiary is Below FRA Throughout the Calendar Year
1. Social Security monthly benefit after the actuarial reduction for early retirement	$2,000	$2,000
2. Calculation of earnings above the annual threshold		
Projected earnings in 2025	$57,280	$63,640
RET threshold in 2025	$23,400	$62,160
Earnings above the threshold	$33,880	$1,480
3. RET Charge	$16,940 (1/2 of the earnings above the threshold)	$493 (1/3 of the earnings above the threshold)
4. Application of the RET: the benefit paid each month equals the monthly benefit amount of $2,000 minus the remaining balance of the RET charge. The RET charge for a given month cannot exceed the benefit for that month, but it may reduce the benefit to zero in some months. A partial benefit is paid if the remaining RET balance is less than the monthly benefit amount.		
January monthly benefit	$0 [a]	$1,507 [b]
February through August monthly benefits	$0 [a]	$2,000
September monthly benefit	$1,480	$2,000
October through December monthly benefits	$2,000	$2,000 [c] plus adjustment of benefits withheld due to the RET which is done at FRA

Source: Source: Congressional Research Service. Notes: This example assumes that the worker's beneficiary receives benefits based only on their own work record. The starting benefit amounts include actuarial reductions for retirement before FRA and any other reductions that may apply. The example is constructed so that the grace year provision does not apply. It assumes that the beneficiary both works and collects benefits over the full calendar year. a. No benefit is paid in these months because the beneficiary's RET balance is larger than the monthly benefit amount, so the RET charge for these months is equal to the monthly benefit amount.

When a beneficiary has had benefits fully or partially withheld under the RET, benefits "lost" due to the RET are restored starting at FRA. Specifically, the worker's benefits are recomputed—and increased—when they attain FRA. In the benefit recomputation at FRA, the actuarial reduction for benefit entitlement before FRA that was applied in the initial benefit computation is adjusted (i.e., the actuarial reduction for early retirement is lessened) to reflect the number of months the worker received no benefit or a partial benefit because of the RET.

Stated generally, if a worker's benefits are reduced in the initial benefit computation to reflect 24 months of early retirement, and the worker subsequently has benefits withheld under the RET for 12 months, the benefit recompilation at FRA will reflect an actuarial reduction for 12 (= 24–12) months of early retirement, resulting in a higher monthly benefit amount starting at FRA. In essence, the worker is treated as if they had claimed benefits a year later than when they did and received the lower actuarial adjustment for early retirement as a result.

Earnings Not Included in the Earnings Test

The following types of income are not counted as "earnings" for the retirement earnings test:

- Any income from employment earned in or after the month the individual reaches FRA. (Self-employment income earned in the year is not examined as to when earned, but rather is prorated by months, even though earned after FRA).
- Any income from self-employment received in a taxable year after the individual becomes entitled to benefits but not attributable to significant services performed after the first month entitled to benefits. This income is excluded from gross income only for purposes of the retirement earnings test.
- Certain payments made under a plan or system established for making payments because of the worker's sickness or accident disability, medical or hospitalization expenses, or death.
- Pensions and retirement plans; payments from certain annuity plans that are exempt from income.
- Interest and dividends from stocks and bonds (unless a dealer receives them in securities during business).
- Gain or loss from the sale of capital assets, or sale, exchange, or conversion of other property that is not stock in trade or includable in inventory.
- Net operating loss carryovers resulting from self-employment activities.
- Loans received by employees unless the employees repay the loans through their work.
- Workers' Compensation and unemployment compensation benefits.
- Veteran's training pay; pay for jury duty; prize winnings from a contest unless the person enters contests as a trade or business.
- Tips paid to an employee that is less than $20 a month or are not paid in cash.
- Payment by an employer that is reimbursement specifically for the employee's travel expenses and that are so identified by the employer at the time of payment.

- Payments from Individual Retirement Accounts (IRAs) and Keogh Plans; and
- Special payments after retirement include bonuses, vacation pay, commissions, sick pay, Insurance commissions, carryover crops, and other special payments. These amounts may be shown on the worker's W-2 in the box labeled "Nonqualified Plan."

Of course, there's no way for the Social Security Administration to know why wages were received, so a beneficiary must tell them in most cases. Concerning explaining the nature of earnings–and trying to exempt them from the earnings test–an individual should file Form SSA-795 (Statement of Claimant or Other Person) and include information such as the amount of wages that should be excluded from the earnings test calculation and the reason such amounts should be excluded.

The Social Security Administration's Office of the Chief Actuary (OCACT) estimated that about 520,000 beneficiaries below FRA (or about 11% of all beneficiaries below FRA) would have had their benefits reduced or completely withheld due to the RET in 2019.

Delaying the Election of Retirement Benefits

If the worker chooses to delay receiving OA retirement benefits beyond FRA, they have two options:

- They can work and get full Old-age retirement benefits no matter how much they earn; or
- They can decide not to collect their retirement benefits until age 70 and then get a higher benefit when they do retire.

Why should workers delay starting Social Security benefits? Because the longer a worker defers benefits, the greater each check will be. For many workers now, the FRA is 67. Clients who defer benefits get a "*delayed retirement credit*" (DRC) for each month they wait. This delayed retirement credit (DRC) amounts to an 8% (simple) increase each year, for those with a full retirement age of 66, or a 32% increase for workers who wait for four full years from age 66 to 70. The benefit would be 132% of their PIA. For those beneficiaries born on or after 1960, with a full retirement age of 67, the DRC at age 70 would be reduced to 124% of their PIA (see Table 3.8).

It is important to note that these dollar amounts are estimates; we do not know what the cost-of-living adjustments (COLAs) will be in the future. However, the percentages by which the PIA is reduced or increased for early or delayed retirement are fixed for each cohort.

For Example: In 2025, a worker who with a normal (full) retirement age of 67, elects to claim benefits at age 62, the maximum Social Security benefit should be about $2,831 per month, or $33,972 a year. If the worker waited until his/her normal (full) retirement age (age 67), their maximum Social Security benefit is estimated to be about $4,043 per month, or $48,516 a year. By waiting until age 70, the maximum Social Security benefit is estimated to be about $5,108 per month, or $61,296 a year.

Table 3.8
Delayed Retirement Credit

Year of Birth	FRA	Credit for each year of delayed retirement age	Benefit, as a percentage of PIA, beginning at age…			
			62	66	67	70
1943–1954	66	8%	75	100	108	132
1955	66 and 2 months	8%	74 1/6	98 8/9	106 2/3	130 2/3
1956	66 and 4 months	8%	73 1/3	97 7/9	105 1/3	129 1/3
1957	66 and 6 months	8%	72 1/2	96 2/3	104	128
1958	66 and 8 months	8%	71 2/3	95 5/9	102 2/3	126 2/3
1959	66 and 10 months	8%	70 5/6	94 4/9	101 1/3	125 1/3
1960+	67	8%	70	93 1/3	100	124

That extra benefit will go on indefinitely if the recipient lives; if this worker has a surviving spouse who did not qualify for the maximum benefit, the extra annual benefit would be paid for the rest of their life (indexed with COLA).

Recompilation of Benefits

Delaying OA retirement benefits and continuing to work beyond a worker's FRA can increase their PIA. A recompilation is automatically considered each year when the worker's earnings are credited to their record. Recompilation of the PIA is processed if the earnings result in an increase to the PIA of at least $1.00. The increase is retroactive to January of the year following the year of new earnings.

Cost-of-Living Adjustments

OA retirement benefits are one of the few sources–for many people, the only source–of retirement income guaranteed to keep pace with inflation. This was made possible with legislation enacted in 1973 and begun in 1975, providing cost-of-living adjustments, or COLAs.

How COLA Is Calculated

Social Security recipients typically receive an annual cost-of-living increase that reflects higher costs associated with inflation. The COLA is based on the change in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) between the third quarter (July-September) of the current year and the third quarter of the most recent year a cost-of-living adjustment was determined.

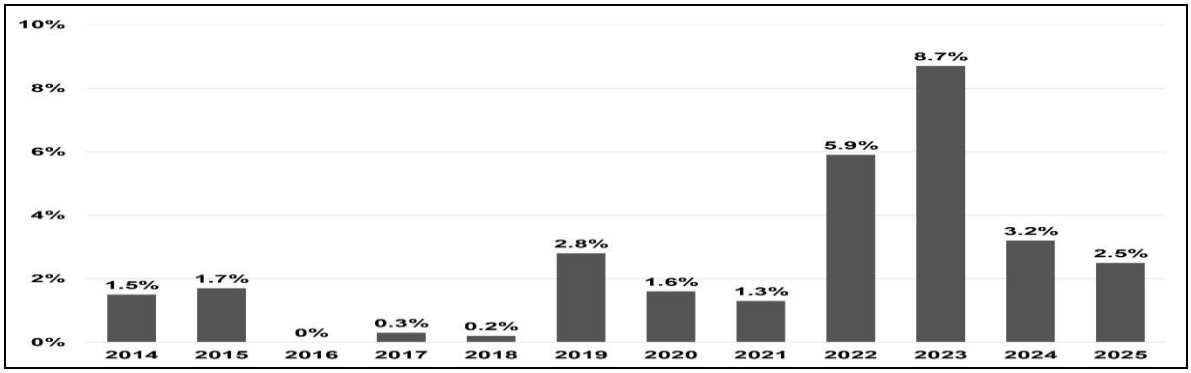
SSA has announced that the more than 72.5 million Social Security and Supplemental Security Income (SSI) benefits will increase 2.5% in 2025.

The 2.5 percent cost-of-living adjustment (COLA) will begin with benefits payable to nearly 68 million Social Security beneficiaries in January 2025. Increased payments to nearly 7.5 million SSI recipients will begin on December 31, 2024. (Note: Some people receive both Social Security and SSI benefits).

That means on average, Social Security retirement benefits will on average add $50 to each monthly benefit check by more than $50 per month starting in January to $1,976, in 2025. The average benefit for a retired couple will grow to $3,089 per month in 2025, up from $3,014 currently.

Figure 3.9 illustrates COLAs received from the years 2014 through 2025.

Figure 3.11
Social Security Cost-Of-Living Adjustments 2014-2025



Source: U.S. Social Security Administration.

Social Security recipients will get the first COLA increase for 2025 in their January benefits. Monthly payment dates are based on a person's birthdate:

- People born between the 1st and 10th of their birth month will get their first COLA increase on January 8
- Those born between the 11th to 20th of their birth month will receive the COLA bump on January 15
- Recipients born between the 21st and 31st of their birth month will get the new COLA on January 22

Meanwhile, people who started collecting Social Security before May 1997 or who receive both Social Security and SSI will get their new Social Security COLA on January 3, 2025.

People receiving SSI will get their new 2025 COLA with their December 31, 2024, payment.

What's The Right Inflation Index?

What's the Right Inflation Index? While COLA is supremely popular, some critics contend that the CPI-W does not represent the price changes faced by retirees, particularly regarding health care. They argue that Social Security should use a more appropriate index. In 1987, Congress directed the Bureau of Labor Statistics to calculate a separate price index for the elderly (62+). This index, called the CPI-E, was constructed back in 1982. Over the period 1983-2021, the average annual increase for the CPI-E was 2.8 percent, compared to 2.5 percent for the CPI-W. Still, the differential has narrowed in recent years. The results from the CPI-E need to be interpreted with caution, as it is not constructed from scratch but rather is calculated by re-weighting data collected for all age groups. As a result, it suffers from several flaws. First, a relatively small number of households are used to determine the expenditure patterns. Second, prices are based on the same geographic areas and retail outlets used by younger people and may not represent older people. Third, the items sampled may not be the same as those bought by the elderly. Finally, the prices used are the same as those reported for younger people and do not reflect any senior discounts. Thus, if the decision were made to employ an index for the elderly, a new index would be needed with a larger sample of older households that uses the prices for the products they buy at the places they shop.

In addition, as policymakers debate ways to reduce the federal budget deficit, several proposals have included a COLA using the Chained-CPI, which grows more slowly than the current calculation (CPI-W). They would reduce spending on Social Security and federally administered programs such as Supplemental Security Income and pensions for veterans. The Chained CPI, first published by the BLS in 2002, accounts for more complex substitutions in response to relative price changes than the CPI-U or the CPI-W. It is therefore considered to be a closer approximation to COLA. The idea is that consumers will substitute items at a lower price when prices increase on all those other items. So, what will be the impact of Social Security solvency switching to a Chained

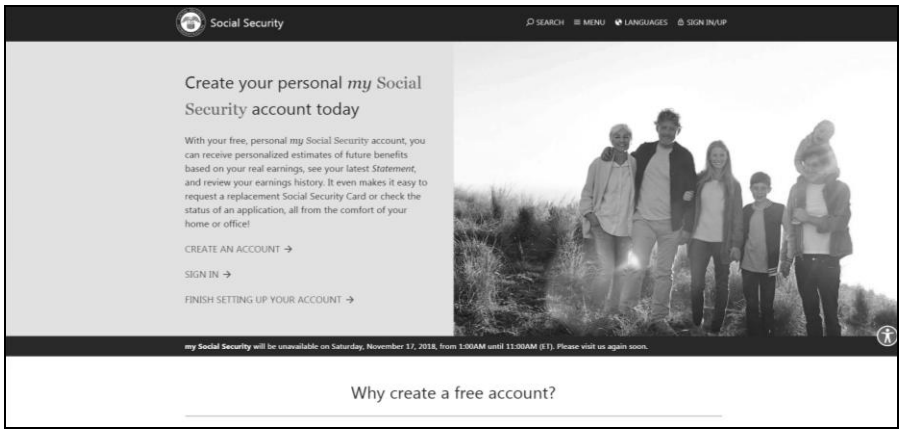
CPI? Social Security actuaries have estimated that changing to a Chained CPI that pays out less in total benefits would close about 23 percent of the 75-year shortfall. It has been estimated that beneficiaries would, on average, see a reduction of about 2% of their benefit over their lifetime. Of course, many policymakers claim that changing to a Chained CPI would have a more detrimental impact on the economic wellbeing of older (especially women) and disabled Americans and their family members who receive benefits from Social Security. Stay tuned!

mySocial Security Account

The Social Security Administration (SSA) has set up a secure portal, *mySocialSecurity* account, to allow workers to verify and manage their Social Security benefits (see Figure 3.10). Creating an account will allow immediate access to your Social Security Statement and access to important information and tools. To date, more than 14 million people have established a personalized *my Social Security* account.

You should verify with your clients that they have set up their *mySocial Security* account. This would allow them to access their Statement from the comfort of their home, office, or library whenever they choose. Individuals who currently receive benefits should sign up for a *mySocial Security* account to manage their benefit payments. When the need arises, they get an instant benefit verification letter, change their address, and phone number, and start or change the direct deposit of their benefit payment. According to Consumer Affairs, the Social Security Administration makes mistakes about 3% of the time. Go over your client's income versus that stated on their Social Security statement, as well as the calculations. If you believe an error has been made, contact the Social Security Administration to have it fixed. Sometimes it can be addressed over the phone. At other times it will require a visit to a local Social Security office. Why? The SSA imposes time limits on correcting your earnings record even if it's not your fault.

Figure 3.10
mySocial Security Account



Source: SSA; https://www.ssa.gov/myaccount/

Social Security New Wage Statement

SSA has redesigned the Wage Statement to make it easier to read and find information that is needed. The redesigned statement now includes a bar graph displaying a worker's personalized retirement benefit estimates at nine different ages, depending on when the worker wants benefits to start. It also includes the worker's earning history and information on reporting an error if the worker finds one.

The Social Security Wage Statement is a valuable financial planning tool providing workers aged 18 and older with important individualized information regarding their earnings, tax contributions, and estimates for future retirement, disability, and survivor benefits.

Fact Sheets Added to Online Statement

SSA has added a new fact sheet to accompany the online Wage Statement. The fact sheets are designed to provide clarity and useful information based on the worker's age group and earnings situation. They can help the worker better understand Social Security programs and benefits.

These fact sheets include:

- Retirement Ready (Fact Sheet For Workers Ages 18-48) [English | Spanish]
- Retirement Ready (Fact Sheet For Workers Ages 49-60) [English | Spanish]
- Retirement Ready (Fact Sheet For Workers Ages 61-69) [English | Spanish]
- Retirement Ready (Fact Sheet For Workers Ages 70 and Up) [English | Spanish]
- Social Security Basics For New Workers [English | Spanish]
- How You Become Eligible For Benefits [English | Spanish]
- Additional Work Can Increase Your Future Benefits[English | Spanish]
- You Have Earnings Not Covered By Social Security [English | Spanish]
- Medicare Ready [English | Spanish]

The biggest change you'll likely notice is that you won't get this statement in your mailbox. My sources tell me the Social Security Administration will never mail these statements, and they'll only be available online.

Moving forward, the only people who still receive the paper version of the Social Security statement are those who are age 60 and older–but only if they don't already have a mySSAaccount. If you do have a mySSA account, don't be surprised if you haven't noticed any changes there yet, either. Only about 20% of individuals with online accounts get the new Social Security statements right now.

Further Reading

Social Security Administration, *How You Earn Credits*; https://www.ssa.gov/pubs/EN-05-10072.pdf

Congressional Research Service, Social Security: Social Security Earnings Test Overview, January 11. 2022 IF12014 (congress.gov)

Congressional Research Service, *Social Security Earnings Test: How Earnings Affect Benefits*; Updated May 10, 2023
https://crsreports.congress.gov/product/pdf/R/R41242

Social Security Administration, *How Work Affects Your Benefits*;
https://www.ssa.gov/pubs/EN-05-10069.pdf

Social Security Administration, How To Correct Your Social Security Earnings Record;
https://www.ssa.gov/pubs/EN-05-10081.pdf

Social Security Administration, Form SSA-7005-SM-OL (05/21)
https://www.ssa.gov/myaccount/statement.html

Chapter 3
Review Questions

1. For Old-Age retirement benefits, a worker is allowed to file for benefits as early as what age?

( ) A. 62
( ) B. 60
( ) C. 50
( ) D. 55

2. The basic Social Security benefit is referred to as:

( ) A. The Average Index Monthly Earnings (AIME)
( ) B. The Primary Insurance Amount (PIA)
( ) C. The Average Wage Index
( ) D. Quarters of coverage

3. Which of the following is used to calculate the Primary Insurance Amount?

( ) A. Average Wage Standard
( ) B. National Average Wage Index
( ) C. Quarters of coverage
( ) D. Average Index Monthly Earnings (AIME)

4. How many years of wages are used to arrive at the average indexed monthly earnings (AIME)?

( ) A. 35
( ) B. 50
( ) C. 10
( ) D. 15

5. What time frame is used to determine the percentage increase for the Social Security COLA?

( ) A. The average CPI-W from the third quarter of the previous year to the third quarter of the current year
( ) B. The average CPI-W from January through December of the current year
.( ) C. The average CPI-W from the second quarter of the previous year to the second quarter of the current year.
( ) D. The average CPI-W from October to December of the current year.

CHAPTER 4

SOCIAL SECURITY AUXILIARY BENEFITS

Overview

Social Security is more than just a retirement benefits program. It is this nation's most important family protection program (OASDI). Children, wives, husbands, and even dependent parents can receive Social Security benefits under certain circumstances.

This chapter will examine the various Social Security auxiliary benefits paid to family members, spouses, dependent children, and parents. It will also examine benefits paid to divorced spouses who meet certain eligibility requirements.

Learning Objectives

Upon the completion of this chapter, you will be able to:

- Review the various auxiliary benefits provided by Social Security.
- Apply the rules for electing and receiving spousal benefits.
- Explain the "deemed filing" rule.
- Determine eligibility for survivor benefits.
- Calculate the survivor, dependent children, and family maximum benefit; and
- Describe the divorced spouse's entitlement to OASDI benefits on an ex-spouse's work record.

Background

Social Security benefits are payable to the spouse, divorced spouse, or child of a retired or disabled worker and the widow(er), divorced widow(er), child, or parent of a deceased worker. When dependent beneficiaries also earn worker benefits, they receive the larger or dependent benefit.

Let's first examine spousal benefits.

Spousal Benefits

A married couple is entitled to "*spousal benefits*" based on the primary beneficiary's (higher-earning spouse) Social Security record if:

- The primary benefits are entitled to retirement or disability benefits.
- The primary beneficiary's spouse has filed an application for the spouse's benefits.
- The primary beneficiary's spouse is not entitled to a retirement or disability benefit based on a PIA equal to or larger than one-half of the primary beneficiary's PIA; and
- The primary beneficiary's spouse is either age 62 or over, has in care a child under age 16 or disabled, and is entitled to benefits on the primary beneficiary's Social Security record.

Note: Having a child in care is a basic requirement for the spouse's benefit when the spouse is under age 62 and for the mother's or father's benefit. "*In-care*" means that the mother or father exercises parental control and responsibility for the welfare and care of a child under age 16 or a mentally incompetent child aged 16 or over or performs personal services for a disabled mentally competent child aged 16 or over.

Defining a Married Couple

On June 26, 2015, the Supreme Court of the United States (SCOTUS) issued a decision in Obergefell v. Hodges, holding that same-sex couples have a constitutional right to marry in all states. As a result, more same-sex couples will be recognized as married for purposes of determining entitlement to Social Security benefits.

Eligibility Requirements for Spousal Benefits

The primary beneficiary's spouse must also meet one of the following conditions:

- Must have been married to the primary beneficiary for at least one year (12 months) just before applying for benefits.
- Must be the natural mother or father of the primary beneficiary's biological child.
- The spouse was entitled or potentially entitled to spouse's, widow(er)'s, parents, or childhood disability benefits in the month before the month of marriage to the worker; or
- Entitled or potentially entitled to a widow(er)'s, parent's, or child's (over 18) annuity under the Railroad Retirement Act in the month before the marriage to the worker.

A spouse is "potentially entitled" if they meet all the entitlement requirements other than filing an application and attaining the required age.

Amount of Spousal Benefits

If the primary beneficiary's spouse of a retired or disabled worker cares for the primary beneficiary's child under age 16 or a disabled child, the monthly benefit equals 50 percent of the primary beneficiary's PIA, regardless of age. If the primary beneficiary's spouse is not caring for a child, monthly benefits starting at full retirement age equal 50 percent of the worker's PIA.

If the primary beneficiary's spouse chooses to start receiving benefits at or after age 62, the benefit is reduced before FRA (see Table 4.1)

Table 4.1
Spousal Benefit Claiming Age

Claimant Filing Age	Spousal Benefit Percent of Spouse's PIA
62	32.50%
63	35%
64	37.50%
65	41.66%
66	45.83%
67 (FRA)	50%

.
If the primary beneficiary's spouse chooses to receive benefits at age 62, their benefit would only be 32.50 percent of the PIA. A spousal benefit is reduced by 25/36 of 1 percent for each month before full retirement age, up to 36 months. If the number of months exceeds 36, the benefit is further reduced by 5/12 of 1 percent per month. This reduction factor is applied to the base spousal benefit, which is 50 percent of the worker's primary insurance amount.

> ***For Example****:* Jack's primary insurance amount (PIA) is $1,600. His wife, Jill, chooses to begin receiving benefits 36 months before her FRA. The first step is to take 50 percent of Jack's PIA ($1,600) to get Jill's $800 base spousal benefit. Then we compute the reduction factor, 36 times 25/36 of 1 percent, or 25 percent. Applying the 25 percent reduction to Jill's spousal benefit of $800 leaves her a spousal benefit of $600. Thus, in this case, Jill's final spousal benefit is 37.5 percent of Jack's PIA (600 divided by $1,600).

Important points to remember: For Jill to receive spousal benefits, her husband Jack must have "*filed for benefits based on his earnings record*." For Jill to be eligible for spousal benefits, Jack must:

- Be already receiving benefits based on his earnings, or
- Once Jack reaches his full retirement age and Jill is eligible for spousal benefits (beginning at age 62), she is "deemed" to be applying for both her own and spousal benefits.

As of May 2025, 1,994,639 million spouses were receiving spousal benefits from retired workers receiving an average monthly benefit of $950.20. Males equaled 143,887 and received an average monthly benefit of $701.42 and 1,850,752 million were female beneficiaries and they received an average monthly benefit of $969.54.

Deemed Filing Rule

Let's take a moment to explain the "*deemed filing*" rule. According to SSA Handbook Section 1510:

> *"If you are eligible for both reduced retirement insurance benefits and reduced spouse's insurance benefits beginning with the same month, you cannot restrict an application to just one of these types of benefits. By filing for either benefit, you are deemed by law to have filed for both types of benefits."*

Now let's put this into perspective using our example of Jack and Jill. If Jill applies for benefits before attaining her FRA and she is eligible for spousal benefits, then she is deemed to be applying for both her own earned worker's benefit and spousal benefits. SSA will calculate both benefits and pay Jill the larger of the two–her own benefits or spousal benefits (if eligible)–but not both. Stated differently, before attaining FRA, Jill cannot apply for spousal benefits only and later switch to her own benefits, or vice versa.

Once a spouse receives reduced benefits, their benefit rate will continue to be payable even after reaching their FRA. The reduced benefit will continue if there is not an entitled child in their care. (SSA Section 729.4).

Note: The Bipartisan Budget Act of 2015 increased the "*deemed filing"* rule up to age 70 (discussed in greater detail in Chapter 5).

Reduction of Spousal Benefits Due to Excess Earnings

As was discussed in Chapter 2, a spouse can lose some or all their monthly benefits if they work and receive excess earnings above the earnings limit.

For 2025 those limits are:

- If the working spouse continues to work and starts receiving benefits before FRA, $1 in benefits will be deducted for each $2 in earnings they earn above the annual limit of $23,400 a year (increased from $21,320 in 2024);
- In the year the working spouse reaches FRA, their benefits will be reduced by $1 for every $3 earned over $62,160 a year (increased from $59,250 in 2024) until the month they reach FRA.

Next, let's examine the rules for Social Security benefits for children.

Social Security Benefits for Children

Children may receive Social Security benefits if a qualified worker retires, becomes disabled, or dies. According to SSA, an eligible child can be the worker's biological child, adopted child, or stepchild. A dependent grandchild may also qualify. There are specific rules for each of these benefits. First, let's examine the rules for retirement or disability benefits (survivor benefits for children will be discussed later in this chapter).

Retirement or Disability Benefits for Children

A child may be entitled to receive benefits on their parent's earnings history when the parent starts taking their Social Security retirement benefits (or qualifies for disability benefits) if they meet the following:

- Younger than age 18; or
- 18-19 years old and a full-time student (no higher than grade 12); or
- 18 or older and disabled before age 22.
- Under certain circumstances, benefits can also be paid to a stepchild, adopted child, dependent grandchild, or step-grandchild.

Amount of Child(ren)'s Benefit

The eligible child of a retired worker or disabled worker is entitled to a monthly benefit equal to 50 percent of their parent's PIA. Usually, this is an amount equal to one-half of the parent's (worker's) benefit. Still, suppose the parent has elected to receive reduced retirement benefits before FRA. In that case, the child's benefit will be based on one-half of their parent's PIA, not on one-half of the reduced benefit. If the parent receives a larger benefit than the PIA due to delayed retirement beyond FRA, the child's benefit is still only 50 percent of the PIA. However, as discussed below, there is a limit to the amount paid to the retired worker and the family (family maximum).

According to the SSA Beneficiary Data, at the end of May 2025, 3,819,036 children were receiving Social Security benefits with an average check of $933.73 (See Table 4.2).

Table 4.2
Number of Children and Total Monthly Benefits, Type of Benefit, May 2025

Type of Beneficiary	Number (thousands)	Average Monthly benefit (dollars)
Children of retired workers	739,096	$925.14
Children of deceased workers	2,080,923	$1,139.18
Children of disabled workers	999,017	$512.13
Total Children	3,819,036	$933.73

Source: SSA Beneficiary Data; https://www.ssa.gov/cgi-bin/currentpay.cgi

Today, family structures vary more than ever. Sometimes, the "restructuring" of families can make children eligible for benefits based on their parent's earnings history, even when the parent is still living.

> ***For Example:*** Suppose Mark, a 60-year-old man, married Mary, a 44-year-old woman with a seven-year-old son, Paul–and Mark adopted Paul. When Mark turns 66 and begins taking $1,000/month in Social Security OA benefits, at 13 years old, Paul can receive $500/month until age 18, totaling $30,000.

Furthermore, the proportion of children living in "grand families" has doubled in the U.S. since 1970 and has increased 7% in the past five years alone. Some 2.6 million grandparents are raising their grandchildren. If a client has legal custody and financial responsibility for a grandchild, this benefit may provide much-needed help.

The age of the children at the time the parent or grandparent begins collecting Social Security is important. If the eligible children or grandchildren are young, there are more years during which their Social Security benefits could be collected.

> ***For Example:*** Tom, a grandfather, begins taking Social Security benefits at the age of 67 in the amount of $1,500. His six-year-old granddaughter Sally (of whom Tom has legal custody) can receive up to 50% of his benefit until he is 18. That means she may receive $750/month for 12 years, totaling $108,000 in benefits.
>
> Tom's 14-year-old grandson Steve, on the other hand, could only receive $750/mo. for four years, totaling only $36,000. (**Note:** There is a family benefit maximum discussed below.)

It's important to remember the guidelines are different for children affected by a disability before age 22. If a child is disabled before age 22, they can start collecting benefits whenever their parent files for Social Security, even though that may be decades later. We are talking specifically about Social Security retirement benefits; the child may also be eligible for supplemental income through other government programs at an earlier age.

> ***For Example:*** Suppose a child, Phillip, was affected by a permanent disability at the age of 12, when his father, Pat, was 40 years old. If Pat starts collecting his Social Security retirement benefits twenty-two years later at 62, Phillip, then age 34, can immediately start collecting benefits based on his father's earning history. This is because Phillip was affected by the disability prior to age 22. Hopefully, this additional benefit doesn't apply to many people, but it can make a significant difference when it does.

Keep in mind; a child is not eligible for any amounts until their parent starts collecting their retirement benefits. Once they do, that may increase the total amount your client's family receives from Social Security. The amounts paid can help cover many typical expenses of raising a child or living with a disability. The tradeoff is that your client may

have to start collecting sooner than they otherwise would, so they would need to make this decision carefully to ensure it's the right choice for them.

Survivor Benefits

The Survivors' Insurance component of OASDI covers insured workers in case of death. When a worker insured by Social Security dies, their family may qualify for survivor benefits.

The Establishment of Survivor Benefits

The Social Security Act of 1935 (P.L. 74-271), which created the Social Security program, did not include any provisions for monthly survivor benefits but did include a lump sum payment upon the death of a fully insured person over the age of 65 (in 2025 the payment is $255).

Monthly survivor benefits were established in the Social Security Amendments of 1939 (P.L. 76-379), including widows, parents, and children. This was offset by a reduction in the size of the lump sum death payment. However, coverage expanded to both fully and currently insured workers, regardless of age. These changes were made to "afford adequate protection to the family as a unit" that could be afforded by a single lump sum payment that did not consider family size or the number of survivors.

How Survivor Insurance Works

Coverage for survivor benefits is based on the insurance status of the deceased worker. To become insured for survivor benefits, a worker must have a sufficient work history in covered employment (employment subject to Social Security payroll taxes). A worker can earn up to four Social Security credits each year, based on their earnings in a covered job. The number of credits a worker needs to qualify for Survivors Insurance depends on how old the worker is when they die.

As was discussed in Chapter 2, a worker is *fully insured* for benefits if they have earned at least one credit for each year between age 21 and turning 62, dying, or becoming disabled; a worker is *permanently insured* if they have at least 40 credits, also referred to as quarters of coverage (at least 10 years of work). In 2025, approximately 87% of Americans over the age of 20 is considered fully insured based on their earnings and contributions to Social Security. Spouses, former spouses, children, and parents of fully insured workers are eligible for survivor benefits if they meet the other requirements for those benefits.

A deceased worker's children and the (former) spouse caring for those children could be eligible for survivor benefits even if the deceased worker were not fully insured—survivor benefits are available to these dependents if the deceased worker were currently insured at the time of death. The deceased worker is *currently insured* if they earned at least six credits during the three years prior to death.

Determining Survivor Benefits

Survivor benefits are determined using the same basic formula used to calculate Social Security retirement and disability benefits. Benefits are based on the average lifetime covered earnings of the worker who died, so survivors of higher earners tend to receive higher benefits than survivors of lower earners. However, the benefit formula is progressive, so survivor benefits replace a higher proportion of lower earners' wages than higher earners' wages.

When a person applies for survivor benefits, the deceased worker's basic benefit amount, called the *primary insurance amount* (PIA), is determined. Each qualifying survivor will receive a percentage of the worker's PIA, depending on the survivor's age and relationship to the deceased worker. Survivor benefits may be subject to reductions based on earnings and family size. If a survivor qualifies for benefits based on both their own work record and a spouse's record, the survivor receives the higher amount of the two. Survivor benefits, like all Social Security benefits, are subject to an annual COLA. In most cases, survivor benefits are payable to eligible family members beginning with the deceased beneficiary's month of death, regardless of when the death occurred during the month.

Types of Survivor Benefits

Survivor benefits can be paid to the following people based on the deceased's PIA record:

- Age widow(er);
- Young widow(er) with a child in care.
- Disabled widow(er);
- Child of a deceased worker; and
- Parent of a deceased worker.

Aged Widow(er) Benefits

An aged widow(er) has dual entitlements under Social Security. They are entitled to benefits based on:

- Surviving spouse's own earnings record; or
- Survivor benefits based on the deceased spouse's earnings record.

To be eligible for aged widow(er)s benefits, the widow(er) must have been married to the worker for at least nine (9) months before the death of the worker. There are some exceptions to the rule:

- The worker died because of an accident.

- The worker's death occurred in the line of duty while they were a member of a uniformed service or active duty; and
- The claimant was previously married to the worker, divorced from them, and the previous marriage lasted at least nine months.

Surviving spouses of fully insured workers must meet an age requirement for widow(er)'s benefits. Divorced surviving spouses may also be eligible if they were married to the deceased worker for at least 10 years. Surviving spouses receive 100% of the deceased worker's PIA if they begin to collect survivor benefits at their full retirement age (FRA).

According to SSA Beneficiary Data, as of May 2025, there were 3,479,366 aged widow(er)s receiving an average monthly benefit check of $1,863.71. Of the 3.5 million age widow(er) beneficiaries, there were 172,281 who were males receiving an average monthly benefit check of $1,626.54 and 3,307,085 were females receiving an average monthly benefit check of $1,876.06.

Note: The FRA for survivor benefits is different than the FRA for a worker's retirement benefit.

Table 4.3 displays the FRA for survivor benefits. This FRA also adopts the caveat whereby someone born on January 1 is considered born in the previous year. For survivor benefits, the FRA is 66 years and two months for someone born in 1957, and it rises by two months per year through 1962. For someone born in 1962 or later, it is age 67.

Table 4.3
Full Retirement Ages for Survivor Benefits for Widow(er)s

If your birth date is…	Then your full retirement age is…
1/2/45–1/1/57	66 years
1/2/57–1/1/58	66 years and 2 months
1/2/58–1/1/59	66 years and 4 months
1/2/59–1/1/60	66 years and 6 months
1/2/60–1/1/61	66 years and 8 months
1/2/61–1/1/61	66 years and 10 months
1/2/62 and later	67 years

Source: http://www.socialsecurity.gov/survivorplan/survivorchartred.html

Table 4.4 illustrates the percentages of benefit available at each age, assuming FRA is 67.

A worker's claiming age affects the widow(er) benefit. If a worker is receiving reduced benefits due to claiming benefits before full retirement age, the widow(er) benefit cannot exceed the worker's reduced benefit amount. For workers entitled (or who would have been entitled) to an increase (or subject to being increased) in their benefit amount due to claiming benefits after full retirement age, their benefits are increased at death to consider

the *delayed retirement credits* from claiming benefits after full retirement age, thereby increasing the widow(er) benefit.

Table 4.4
Age-Based Reduction & Increases

Filing Age	Survivor Reduction or Increase
50 – 59	71.5%*
60	71.5%
61	75.6%
62	79.6%
63	83.7%
64	87.8%
65	91.9%
66	95.9%
67	100%**
68	100%
69	100%
70	100%

*Only didabled individuals can file for survivor benefits as early as age 50. For non-disabled individuals the age is 60. ** Assuming full retirement age)FRA) 67.

Widow's Limit Rule

A special rule applies in cases only when the deceased started collecting before their FRA. It is referred to as the "Widow's Limit," or the Retired Insurance Benefit—Limitation, RIB-LIM.

The rule states that the survivor is entitled to the higher of two amounts: the actual benefit of the deceased or 82.5% of the deceased's PIA. This can help survivors tremendously , especially if their partner filed at 62!

Survivor Benefits for Young Widow(er) With Child in Care

A young widow(er) caring for a deceased worker's child who is under age 16 or disabled is eligible for a monthly benefit potentially equal to 75 percent of the deceased worker's PIA. Note: Due to the marriage penalty, a young widow(er) who remarries (prior to age 60) will lose this survivor benefit.

A young widow(er) caring for a deceased worker's child who is under age 16 or disabled is eligible for a monthly benefit potentially equal to 75 percent of the deceased worker's PIA. Note: Due to the marriage penalty, a young widow(er) who remarries (prior to age 60) will lose this survivor benefit.

According to the SSA Beneficiary Data, as of May 2025, there were 99,159 Young Widow(er)s with Child in care receiving an average monthly benefit check in the amount

of $1,314.10. Of the 99,159 Young Widow(er)s with Child, 7.952 were men receiving a monthly benefit check in the amount of $1.152.59 and 91,207 were female, receiving a monthly benefit check in the amount of $1,328.18.

Children of Deceased Worker

Each child who is unmarried and is under age 18 of a worker who dies, is eligible to receive Social Security survivor benefits. The child can also be eligible if he or she is up to age 19 and attending elementary or secondary school full-time.

And a child can get benefits at any age if they have a qualifying disability that began before age 22 and remains the same. Besides the worker's natural children, their stepchildren, grandchildren, step-grandchildren, or adopted children may receive benefits under certain circumstances.

The amount of the benefit potentially equals 75 percent of the deceased's PIA.

According to the SSA Beneficiary Data, as of May 2025, there were 2,080,923 children of deceased workers receiving an average monthly benefit check in the amount of $1,139.18. Of the total 2,080,923 children, 1,288,579 were minor children receiving an average monthly benefit check of $1,105.07, 707,357 were disabled children receiving an average monthly benefit check $1,184.05, and 84,987 were a student receiving a monthly benefit check of $1,282.82.

Disabled Widow(er)

According to the SSA Beneficiary Data, as of May 2025, there were 194,237 disabled widow(er)s receiving an average monthly benefit check in the amount of $953.73. Of the total 194,237 disabled widow(er)s, 17,269 were male receiving an average monthly benefit check of $749.54, 176,968 were female receiving an average monthly benefit check $973.65.

Survivor Benefits for Dependent Parent

A dependent parent aged 62 or older is eligible for monthly benefits equal to 82.5 percent of the worker's PIA. When two dependent parents qualify for benefits, the monthly benefit for each is equal to 75 percent of the deceased worker's PIA. Monthly benefits payable to survivors are reduced to conform to the family maximum payable on the deceased worker's account.

According to SSA Beneficiary Data, as of May 2025, there were 745 dependent parents receiving an average monthly check of $1,697.90. Of the 745 dependents, 97 were men receiving a $1,602.20 monthly benefit check and 648 were females receiving a monthly benefit check of $1,712.22.

Survivor Beneficiaries and Monthly Benefits

As of May 2025, over 5,854,430 survivor beneficiaries, representing 9 percent of the total OASDI beneficiary population, receive an average monthly benefit of $1,566.66 (see Table 4.5).

Table 4.5
Survivor Beneficiaries and Average Monthly Benefits, May 2025

Type of Benefit	Total Beneficiaries	Average Monthly Benefit
All Survivors	**5,854,430**	**$1,566.66**
Aged widow(er)	3,479,366	$1,863.71
Young widow(er) with Child in Care	99,159	$1,314.10
Children of deceased workers	2,080,923	$1,139.18
Disabled widow(er)s	194,237	$953.73
Parent of deceased worker	745	$1,697.90

Source: Social Security Administration, Benefits Paid by Type of Beneficiary
Social Security beneficiaries by age (ssa.gov)

Maximum Family Benefits

The SSA imposes a limit on benefits that go to a family based on one person's earnings record (generally between 150 percent and 180 percent of the breadwinner's amount, though potentially as high as 188 percent). This is called the *family maximum.* Generally, no more than the established maximum can be paid to a family, regardless of the number of beneficiaries entitled on that Social Security record. The family maximum is determined by computing the PIA and the kind of benefits payable to a worker.

Computation of the Retirement and Survivor Family Maximum

The formula used to compute the family maximum is like that used to compute the PIA. The PIA formula sums four separate percentages of portions of the worker's PIA. For 2025, these portions are the first $1,567, the amount between $1,567 and $2,262, the amount between $2,262 and $2,950 and the amount over $2,950. These dollar amounts are the "bend points" of the family-maximum formula.

Table 4.6 illustrates the bend points for the years 2015-2025.

Table 4.6
Maximum Family Benefit PIA Formulas, 2015 - 2025

Year	Dollar Amounts in Maximum Family Benefit		
	First	Second	Third
2015	$1,056	$1,524	$1,987
2016	$1,093	$1,578	$2,058
2017	$1,131	$1,633	$2,130
2018	$1,145	$1,652	$2,155
2019	$1,184	$1,708	$2,228
2020	$1,226	$1,770	$2,309
2021	$1,272	$1,837	$2,395
2022	$1,308	$1,889	$2,463
2022	$1,308	$1,889	$2,463
2023	$1,425	$2,056	$2,682
2024	$1,500	$2,166	$2.825
2025	$1,567	$2,262	$2,950

Source: http://www.ssa.gov/OACT/COLA/bendpoints.html

For the family of a worker who becomes disabled at age 62 or dies in 2025 before attaining age 62, the total amount of benefits payable will be computed so that it does not exceed:

- 150 percent of the first $1,567 of the worker's PIA, plus
- 272 percent of the worker's PIA over $1,567 through $2,262, plus
- 134 percent of the worker's PIA over $2,262 through $2,950, plus
- 175 percent of the worker's PIA over $2,950.

We then round this total amount to the next lower multiple of $.10 if it is not already a multiple of $.10. Table 4.7 illustrates how to determine the family-maximum bend points for 2025.

Table 4.7
Determination of Family-Maximum Bend Points for 2025

Amounts in Formula	**Average Wage indices:** For 1977: 9,779.44 For 2021: 66,621.80
	Bend points for 1979 First: $230 Second: $332 Third: $433
Computation of bend points for 2025	**First bend point**: $230 times $66,621.80 divided by $9,779.44 equals $1,566.86, which rounds to $1,567. **Second bend point**: $332 times $66,621.80 divided by $9,779.44 equals $2,261.73, which rounds to $2,262. **Third bend point**: $433 times $66,621.80 divided by $9,779.44 equals $2,949.78, which rounds to $2,950.

Source: www.socialsecurity/gov/OACT/COLA/familymax.html

Adjusting the Family Maximum

The adjustment for the family maximum is made by proportionately reducing all the monthly benefits subject to the family maximum on the Social Security earnings record (except for retired workers' or disabled workers' benefits). All benefits subject to the family maximum are reduced to bring the total monthly benefits payable within the limit for the particular case.

Exceptions to the Family Maximum

Under SSA Section 731.5, the entitlement of a divorced spouse to a spouse's insurance benefit does not reduce the benefits of other categories of beneficiaries. However, if he/she qualifies for benefits as a surviving divorced mother or father caring for the deceased divorced worker's child, benefits may affect the amount of benefits the deceased worker's other survivors will receive based on his/her earnings record.

Note: The family maximum for disability insurance benefits after June 1980, first eligibility after 1978 is 85% of the AIME. However, it cannot be less than the PIA nor more than 150 percent of the PIA.

Social Security Benefits for a Divorced Spouse

A divorced ex-spouse may be entitled to Social Security benefits based on retirement, survivor, and disability benefits. Each benefit has its separate rules. First, let's examine the rules for a divorced spouse to receive retirement benefits based on the ex-spouse's work record.

Death Benefit Payment

In addition to monthly survivor benefits, a deceased worker's family may be eligible to receive a one-time death benefit of $255. Only one lump sum death benefit is payable to the family of an insured worker. The lump sum death benefit is paid to the insured worker's surviving spouse, regardless of age, if the spouse meets certain requirements.

To qualify, a spouse must be living with the worker at the time of death or eligible to receive certain Social Security benefits based on the worker's record in the month of death. The rules regarding when a couple is considered to live together are provided in 20 C.F.R. §404.347. Generally, they require the couple to live in the same residence unless separated due to a temporary absence, military service, or one person being confined to a nursing home or other medical facility.

If no eligible widow(er) exists, the death benefit is paid in equal shares to any children who qualify for child's benefits based on the deceased worker's record. If a worker leaves no eligible spouse or child, the lump sum death payment will not be paid. If a

deceased worker had enough credits, a one-time payment of $255 also would be made after the worker's death. This benefit may be paid to the deceased worker's spouse or minor children if they meet certain requirements.

In 2018 (latest data available), the Social Security Administration (SSA) paid about $207 million in lump sum benefits for 794,909 deaths.

Because the $255 payment was split between multiple recipients in some cases, the agency made a total of 832,746 payments. The number of payments is projected to remain at about the same level during the next few years; thus, total spending will remain at approximately the same dollar level.

For most deaths, no lump sum death benefit is paid. In 2018, fewer than 40% of the deaths among insured workers resulted from lump sum death benefit payments. One possible reason was that, for many deaths, there was no eligible family member to receive the death payment.

For more detailed information about the lump sum death benefit, you can view the CRS Report R43637, *Social Security: The Lump Sum Death Benefit* at*:* Social Security: The Lump-Sum Death Benefit (congress.gov)

Summary of Auxiliary Benefits

Table 4.8 provides a summary of Social Security auxiliary benefits for the family of a retired, disabled, or deceased worker, including eligibility requirements related to age and other factors.

Table 4.8
Social Security Auxiliary Benefits

Basis for Entitlement	Basic Eligibility Requirements	Basic Benefit Amount Before Any Adjustment
Spouse	**At least age 62** The worker on whose record of benefits is based must be receiving benefits.	**50% of worker's PIA**
Divorced Spouse (If the divorced individual was married to the worker for at least 10 years before the divorce became final and is currently unmarried)	**At least age 62** Generally, the worker on whose record of benefits is based must be receiving benefits. However, a divorced spouse may receive benefits on the worker's record if the worker is eligible for (but not receiving) benefits and the divorce has been final for at least two years.	**50% of worker's PIA**

Widow(er) & Divorced Widow(er) (If the divorced individual was married to the worker for at least 10 years before the divorce became final and did not remarry before age 60)	**At least age 60**	**100% of worker's PIA**
Disabled Widow(er) & Divorced Disabled Widow(er) (If the divorced individual was married to the worker for at least 10 years before the divorce became final and did not marry before age 50)	**At least age 50** The qualifying disability must have occurred: (1) before or within seven years of the worker's death; or (2) within seven years of having been previously entitled to benefits on the worker's record as a widow(er) with a child in their care; or (3) within seven years of having been previously entitled to benefits as a disabled widow(er) that ended because the qualifying disability ended (whichever is later).	**100% of worker's PIA**
Mothers and Fathers	Surviving parent of any age who cares for the deceased worker's child, when that child is either under the age of 16 or disabled. Eligibility generally ceases if the surviving mother or father remarries.	**75% of deceased worker's PIA** (Subject to the maximum family benefit amount)
Parents	At least age 62 and has not married since the worker's death. The parent must have been receiving at least one-half of his or her support from the worker at the time of the worker's death or, if the worker had a period of disability that continued until death, at the beginning of the period of disability.	**If one parent is entitled to benefits: 82.5% of deceased worker's PIA.** **If two parents are entitled to benefits: 75% of deceased. worker's PIA** (for each) (subject to the maximum family benefit amount)
Child(ren)	A child (including a dependent, unmarried biological child, adopted child, stepchild, and, in some cases, grandchild) of a retired, disabled, or deceased worker who was fully or currently insured at the time of death. The child must be: (1)	**50% of worker's PIA for a child of a retired or disabled worker** **75% of deceased worker's PIA for a child**

	under age 18; or (2) a full-time elementary or secondary student under age 19; or (3) a disabled person aged 18 or older whose disability began before age 22.	**of a deceased worker** (Subject to the maximum family benefit amount)

Source: Congressional Research Service. Notes: The maximum family benefit may apply, reducing the benefit received by each family member on a proportional basis. The maximum family benefit varies from 150% to 188% of a retired or deceased worker's PIA. For the family of a worker who is entitled to disability benefits, the maximum family benefit is the lesser of 85% of the worker's AIME or 150% of the worker's PIA, but no less than 100% of the worker's PIA.

Further Reading

Social Security Administration; Benefits for Children; https://www.ssa.gov/pubs/EN-05-10085.pdf

Social Security Online Beneficiary Data
https://www.ssa.gov/cgi-bin/currentpay.cgi

Social Security Administration, *Survivor Benefits*, https://www.ssa.gov/pubs/EN-05-10084.pdf

Congressional Research Report, November 14, 2019
Social Security: The Lump-Sum Death Benefit (congress.gov)

Social Security Beneficiaries by Age
Social Security beneficiaries by age (ssa.gov)

Chapter 4
Review Questions

1. A monthly survivor benefit equal to what percent of the deceased worker's PIA is payable to the surviving spouse of a worker who was fully insured at the time of death?

( ) A. 50%
( ) B. 80%
( ) C. 75%
( ) D. 100%

2. The eligible child of a retired or disabled worker is entitled to a monthly benefit equal to what percent of their parent's primary insurance amount (PIA)?

( ) A. 80%
( ) B. 50%
( ) C. 75%
( ) D. 100%

3. The maximum family benefit payable based on one worker's record generally ranges from what percent of the worker's PIA.

( ) A. 150%–180%
( ) B. 125%–150%
( ) C. 150%–225%
( ) D. 180%–220%

4. Social Security will pay a death benefit of what amount in 2025?

( ) A. $180
( ) B. $225
( ) C. $255
( ) D. $525

5. For a divorced spouse to receive benefits based on the ex-spouse's record, they must have been married for how many years prior to the divorce?

( ) A. 10 years
( ) B. 3 years
( ) C. 7 years
( ) D. 1 year

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CHAPTER 5

STRATEGIES TO MAXIMIZE SOCIAL SECURITY BENEFITS

Overview

According to the Social Security Administration (SSA), Social Security replaces about 40% of an average wage earner's income after retiring. The problem is that research shows that more than three of every four Americans trim their monthly checks for life by claiming benefits too early. This mistake costs retirees hundreds of millions a year and can be easily prevented with education and proper planning.

This chapter will examine strategies from the simplistic break-even analysis used for individuals to some of the more advanced strategies used for married couples. It will review the "switching strategies" that were used to maximize benefits for married couples prior to the enactment of the BBA of 2015, and the current strategies being used to maximize spousal benefits, survivor benefits and benefits for divorced ex-spouses.

Learning Objectives

Upon completion of this chapter, you will be able to:

- Explain the advantages and disadvantages of applying for Social Security benefits.
- Present the pros and cons of using the Social Security break-even analysis.
- Describe the strategies used to maximize benefits prior to the enactment of the Bipartisan Budget Act (BBA) of 2015.
- Explain how the planning to coordinate and maximize spousal benefits after the BBA of 2015.
- Determine planning opportunities with the new Social Security rules after the passage of the Bipartisan Budget Act (BBA) of 2015 for spousal benefits and survivor benefits.
- Explain the methods and benefits for voluntary suspension of benefits; and
- Explain the rules and benefits for divorced ex-spouses.

Let's first begin by explaining the rules for applying for Old Age retirement benefits.

Applying for OA Retirement Benefits

Applying for Old-Age (OA) retirement benefits in the United States is largely a personal choice. Although your client may apply for OA retirement benefits as early as age 62, doing so may permanently reduce their monthly benefit payments by 25%–30% for their lifetime (depending on their FRA), spousal benefits and survivor benefits can also be limited depending on circumstances.

Early benefits have appealed to those who are not working, need cash flow, or are concerned that Social Security's days may be numbered ("take the money and run" philosophy). There certainly is no one-size-fits-all answer to the question of when your client should begin claiming OA retirement benefits. While calculating the breakeven age is important, it should not be the sole determinant in the decision.

So, before you turn to the online calculators and excel spreadsheets to work out which option may give your client the maximum amount of OA retirement benefits, you should find out if there is some reason why they absolutely should–or should not–take either early or delayed benefits. Here are some factors to take into consideration.

Immediate Financial Need

Your client may be in a financial situation that leaves them no choice–they need their retirement benefits now, even though their monthly benefits will be lower than if they waited. Their total lifetime benefits will probably be lower.

Life Expectancy

How long your client, and if married, their spouse expects to live will have a major impact on any strategy to maximize retirement benefits. However, according to the Stanford Center on Longevity, many people make the common mistake of confusing life expectancies at birth with remaining life expectancies at their current age.

People in their 50s or 60s might find they have another 20 or 30 years to live–or more. It's important to understand that estimated life expectancies aren't someone's destiny. Life expectancy is just a calculated average time that someone might expect to live based on assumptions about mortality rates. It's entirely possible that a person could live well beyond their life expectancy–or fall short. Using statistical terms, the standard deviation around calculated life expectancies is quite large.

The Society of Actuaries (SOA) sponsors a simple longevity illustrator that estimates the possible range of lifespans for individuals or couples. For example, according to the SOA longevity illustrator, a 65-year-old woman who doesn't smoke and self-reports average health has a 50/50 chance of living at least another 23 years to age 88. She also has a 25 percent chance–one out of four–of living another 26 years to age 91. One out of four is the odds of drawing a diamond out of a deck of cards.

On the other hand, the odds that this same woman will pass away before age 81, living 16 years or less after age 65, are also one out of four. This could be the odds of drawing a club out of that same deck of cards. The range between these two possible "one out of four" lifespans is 10 years, illustrating the uncertainty surrounding how long people might live.

Similarly, the SOA longevity illustrator shows that a 65-year-old man has a 50/50 chance of living another 20 years to age 85. The remaining lifespans with "one out of four" odds range from passing away by age 83 (only 13 more years) to living at least until age 92.

The SOA longevity illustrator also allows a couple to see how long their money might need to last–if one of them is still alive. For instance, if the 65-year-old man and woman mentioned above were married, there's a 50/50 chance one of them will be alive in 27 years, surviving to age 92. The "one out of four" remaining lifetime ranges from 22 to 32 years.

It's just one of life's realities that people could live for a long time–or not long at all. It's just not possible to know for sure.

The website www.Flowingdata.com provides a visual and impactful illustration of the different potential lifespans someone might experience. Input a person's current age and gender, and a fascinating animated chart plays out the possible future lifespans. Some lifespans are short, some are long, but frequently, the span is somewhere between these two extremes.

Rule of Thumb: If a single individual dies well before age 80, they will maximize lifetime benefits by starting benefits at age 62. If they live past 80, they will maximize lifetime benefits by starting benefits at 70.

Marital Status

If your retiree is married, spouses should decide together because the age they apply for retirement benefits may affect the amount their surviving spouse will receive after their death. The general rule is that the higher-earning spouse (primary beneficiary-worker) should delay applying for retirement benefits because that is the benefit that will prevail after either spouse dies. Assuming the husband is the higher-earning spouse, the longer he waits to apply–up to age 70–the higher the retirement benefit for himself while alive and for his widow after his death.

Rule of Thumb*:* The relevant life expectancy for the decision of when the higher-earning spouse (primary beneficiary-worker) should begin benefits based on their earnings record is the lifetime of the second spouse to die, while the relevant life expectancy for the decision as to when the spouse with the lower PIA should begin benefits based on their record is the lifetime of the first spouse to die. If at least one spouse lives well beyond the age when the primary beneficiary would turn 80, the couple's cumulative lifetime benefits will usually be highest if the higher earner delays benefits based on his record until age 70.

The Simple Break-Even Analysis of a Misleading Tool

Those thinking about whether to claim their Social Security benefits now or later often ask the following question:

> "*If I delay claiming and give up benefits now in return for greater benefits later on, how many years must I wait to get those forgone benefits back?*"

This is known as the "Social Security break-even time period" question.

One simple way to compare the three basic alternatives–begin benefits at age 62, delay retirement until age 70, or begin benefits at the full retirement age (FRA)–is to ignore alternative uses of the money. In other words, simply look at which alternative gives the most cumulative amount of gross benefits over the expected life of the retiree.

Actuarially speaking, a person who lives exactly as predicted should receive substantially the same cumulative amount of benefits regardless of choice. Regardless of the statistics, a retiree's expectations of his/her longevity will drive the decision. Waiting past age 62 to claim retirement benefits seems costly: it would forget cash in hand. Waiting also offers a substantial advantage: each year delaying the claim, the benefits increase for the rest of life. Those benefits are inflation protected. The tradeoff between smaller monthly benefits immediately versus larger benefits later can be expressed as a rate of return (or an interest rate) on an investment. This rate of return measure can then be easily compared to other investments.

To illustrate, suppose you could get $9,000 a year in benefits by claiming at 62. If you waited until age 63 to claim, you would get $9,600. So, you give up (invest) $9,000 to get $9,600 (inflation-adjusted) for the rest of your life. If you are a male with a normal life span of 82 years, the implied annualized rate of return on such an "investment" is 2.9%. A female with a normal life expectancy of 86 would receive a rate of return of 4.2% since she receives the extra money for more years. Note these are inflation-adjusted rates of return. If the average COLA over the next 25 or so years is 2%, then the "nominal" rates of return (not adjusted for inflation) for the illustration above would be 4.9% and 6.2%, respectively.

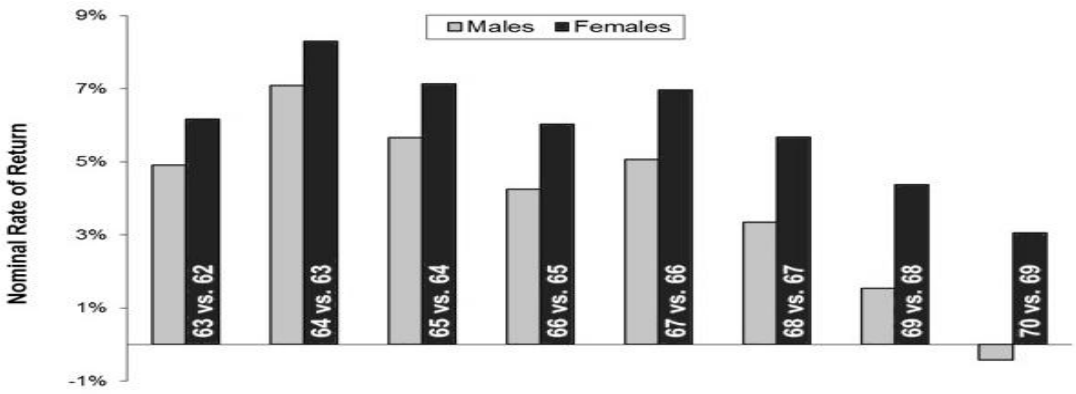
Generally, we think about interest rates or returns in nominal terms rather than in inflation-adjusted terms. So, in what follows, we will use nominal rates of return, assuming a long-term inflation rate of 2%.

Table 5.1 illustrates the various rates of returns to waiting an additional year for both single males and females. We have discussed the rates of return from waiting until age 63; in the figure, those numbers are indicated by the first two bars (left for males; right for females).

If you are now 63, what's to be gained from waiting until 64? The figure shows that men with a normal life expectancy would capture an annualized rate of return of 7.1%. For women, it is 8.3%. The interpretation for other waiting periods follows the same pattern.

Note: By comparison to the nominal yields shown in the graph, 10-year Treasury bonds (close to a risk-free investment, like Social Security) were yielding 2.0% annually if held to maturity, while 30-year Treasury bonds were yielding about a 3.20% annualized return to maturity.

Table 5.1
Claiming Age Comparisons- Nominal Rate-of-Return



Source: SocialSecurityChoices:
http://www.socialsecuritychoices.com/info/social_security_as_investment.php

So, if you compare the implied rates of return to waiting for Social Security benefits with comparable very low-risk investments, you can see that waiting can be a superior investment strategy. (Using stocks in the comparison is not appropriate since they involve far more risk than what we are considering here.)

For singles, it is important to note that the rates of return to waiting depend only on life expectancy. The absolute level of benefits is irrelevant to the calculation. So, for singles with life expectancies longer than normal, the rates of return to waiting are higher than those shown above. With below-average life expectancies, the rates of return are lower.

A further point to consider when an individual is contemplating taking early OA retirement benefits is whether they plan to continue working and will be subject to the retirement earnings test (RET). Earnings that might reduce a worker's OA retirement benefit include wages they earned as an employee, net earnings from self-employment, and other types of work-related income such as bonuses, commissions, and fees. Earnings that will not reduce their benefit include pensions and retirement pay, Workers' Compensation or unemployment benefits, prize winnings from contests unless they are part of a salesperson's wage structure, tips that are less than $20 per month, payments from retirement accounts, investment income or income earned in or after the month reaching FRA.

Next, let's examine how to maximize benefits for single individuals.

Maximizing Benefits for Singles Individuals

It is recommended that advisors review two criteria when recommending single individuals (and couples) when to take OA retirement benefits. They are:

- Maximize expected cumulative lifetime benefits; and
- Minimize longevity risk.

Table 5.2 presents cumulative lifetime benefits through ages 70, 75, 80, and so on in five increments through age 100 if Social Security benefits begin at age 62 through 70. It assumes the individual has an FRA of 66 and a Primary Insurance Amount (PIA) of $2,000, but the relative sizes of cumulative lifetime benefits are identical for other PIA levels. All benefit amounts are expressed in today's inflation-adjusted dollars. Therefore, cumulative benefits represent the lifetime consumption power of Social Security benefits (without considering taxes).

The age 80 column in Table 5.2 illustrates this lesson. If a single retiree lives to 80 cumulative lifetime benefits are similar no matter what age benefits begin. According to Reichenstein and Meyer, age 80 is when cumulative benefits are closest, no matter when benefits begin.

Table 5.2
Cumulative Lifetime Benefits through Ages 70 to 100 if Social Security Benefits Begin at Ages 62 through 70

Ages	70	75	80	85	90	95	100
62	**$144,000**	**$234,000**	$324,000	$414,000	$504,000	$594,000	$684,000
63	$134,400	$230,400	$324,000	$422,400	$518,400	$614,400	$710,400
64	$124,800	$228,801	$326,400	436,802	$540,802	$644,802	$748,803
65	$112,000	$223,999	$332,801	$447,998	$559,998	$671,998	$783,997
66	$96,000	$216,000	$335,999	$456,000	$576,000	$696,000	$816,000
67	$77,760	$207,360	**$336,960**	$466,560	$596,160	$725,760	$855,360
68	$55,680	$194,880	$334,080	$473,280	$612,480	$751.680	$890,880
69	$29,760	$178,560	$327,360	**$476,160**	$624,960	$773.760	$922,560
70	$ 0	$158,400	$316,800	$475,200	**$633,600**	**$792,000**	**$950,400**

Source: *How to Optimize Retirement Benefits: Social Security Strategies*, William Reichenstein and William Meyer (2011), page 19

Table 5.2 also demonstrates that if a single individual has a much shorter-than-average lifetime, cumulative benefits are maximized when benefits begin at 62. If the individual has a much longer-than-average lifetime, cumulative benefits are maximized when benefits begin at 70.

For Example: If a single individual lives to age 75, cumulative benefits are maximized at $234,000 when benefits begin at 62. This cumulative benefit level is $18,000 larger than if benefits begin at 66 and more than $75,000 larger than if benefits begin at 70. If the individual lives to 95, cumulative lifetime benefits are maximized at $792,000 when benefits begin at 70. His cumulative benefits level is almost $100,000 larger than if benefits begin at 66 and almost $200,000 larger than if benefits begin at 62.

Based on the two criteria, Reichenstein and Meyer made the following recommendations to singles in each of the following five groups:

- *Life expectancy of less than 75 years:* This group consists of single individuals with expected lifetimes of less than 75 years. "We recommend beginning benefits as soon as possible–at age 62 or 62 and one month depending upon birth date–or as soon as all benefits would not be lost due to the earnings test. We base this recommendation on your projected lifetime. If an individual dies before age 75, cumulative lifetime Social Security benefits will be highest if benefits begin at age 62. However, be aware that, should the individual live to at least age 77, beginning benefits at 62 will result in lower lifetime benefits than starting benefits at age 64, and it could increase the risk that the financial portfolio will be exhausted during the individual's lifetime;"
- *Life expectancy of at least 75 but less than 77 years:* This group consists of single individuals with expected lifetimes of at least 75 years but less than 77 years. "We recommend beginning benefits at age 64. We base this recommendation on your projected lifetime. It is also important to consider two criteria when deciding when to begin benefits: maximizing expected cumulative lifetime benefits and minimizing longevity risk, that is, the risk of an individual depleting their financial portfolio in their lifetime. Assuming a Full Retirement Age (FRA) of 66, if an individual dies at age 76 (the midpoint in this range), the cumulative lifetime benefits, if benefits were begun at 64, will be 1% lower than if benefits were begun at age 62. However, beginning benefits at 64 would also increase the monthly benefit by 15.6% and thus lower longevity risk should the individual live considerably longer than expected. We believe most single individuals in this group would consider starting benefits at 64 to be a good tradeoff between these two criteria:"
- *Life expectancy of at least 77 but less than 80 years:* This group consists of single individuals with expected lifetimes of at least 77 but less than 80 years. "We recommend beginning benefits at age 67. We base this recommendation on your projected lifetime. It is also important to consider two criteria when deciding when to begin benefits: maximizing expected cumulative lifetime benefits and minimizing longevity risk, that is, the risk of an individual depleting their financial portfolio in their lifetime. Assuming an FRA of 66, if an individual dies at age 78.5 (the midpoint in this range), cumulative lifetime benefits, if benefits are begun at 67, will be about 1% less than the maximum cumulative benefit, which occurs if benefits are begun at 64 years and nine months. However, beginning benefits at 67 instead of 64 years and nine months would increase the monthly benefit by 17.8%. Thus, lower longevity

risk should the individual live considerably longer than expected. We believe most single individuals in this group would consider starting benefits at 67 to be a good tradeoff between these two criteria:"

- *Life expectancy of at least 80 but less than 83 years:* This group consists of single individuals with expected lifetimes of at least 80 but less than 83 years. "We recommend beginning benefits at age 69. We base this recommendation on your projected lifetime. It is also important to consider two criteria when deciding when to begin benefits: maximizing expected cumulative lifetime benefits and minimizing longevity risk, that is, the risk of an individual depleting their financial portfolio in their lifetime. Assuming an FRA of 66, if an individual dies at age 81.5 (the midpoint in this range), the cumulative lifetime benefits, if benefits were begun at 69, will be 1% lower than if benefits were begun at age 67 and six months. However, beginning benefits at 69 instead of 67 and six months would increase the monthly benefit by 10.7%. Thus, the lower longevity risk should the individual live considerably longer than expected. We believe most single individuals in this group would consider starting benefits at 69 to be a good tradeoff between these two criteria:" and
- *Life expectancy of at least 83 years:* This group consists of single individuals with expected lifetimes of at least 83 years. "We recommend delaying the beginning of Social Security benefits until age 70. We base this recommendation on your projected lifetime. It is also important to consider two criteria when deciding when to begin benefits: maximizing expected cumulative lifetime benefits and minimizing longevity risk, that is, the risk of an individual depleting their financial portfolio in their lifetime. Consider a single person with a life expectancy of 83 years. Assuming an FRA of 66, if an individual dies at age 83, the cumulative lifetime benefits from starting benefits at 70 instead of 69 will increase the monthly benefit by 6.5% and thus lower longevity risk should the individual live considerably longer than 83. We believe most single individuals in this group would consider starting benefits at 70 to be a good tradeoff between these two criteria. Individuals with life expectancies beyond age 83 should have an even stronger preference for delaying benefits until 70 since this starting date would likely maximize their expected cumulative benefits as well as minimize their longevity risk."

The bottom line: Every single individual should consider their life expectancy and the relative importance of the two criteria discussed above. Singles who are relatively confident they will die well before 80 will probably want to begin benefits as soon as possible. Singles who expect to live well past 80 will probably want to delay the start of benefits, probably until age 70. Singles who expect to live to about 80 and are concerned about longevity risk will probably want to delay benefits until after FRA, possibly until as late as age 70.

A married spouse might be receiving a spousal benefit, a worker benefit, or a survivor benefit at one time or another. Whether both spouses worked and earned benefits or whether only one spouse did, there are ways to optimize benefits by developing a claiming strategy.

Next, let's examine some strategies to maximize spousal benefits under the old and new rules after enacting the Bipartisan Budget Act of 2015.

Strategies to Maximize Benefits for Married Couples

While strategies for married couples are more complex than strategies for singles, there is also a greater opportunity to add value by helping couples select their claiming strategy.

For married couples, a couple of strategies ("loopholes") were made available after enactment of the *Senior Citizens' Freedom to Work Act of 2000*, signed into law by then-President Bill Clinton. The "loopholes" allowed the following "switching strategies" which allowed one spouse to file for a limited benefit and then later switch to a larger benefit:

- The "File and Suspend" strategy.
- The "Restricted Application" strategy; and
- The Combination strategy.

The Bipartisan Budget Act of 2015, signed into law on November 2, 2015, by President Barrack Obama, made several of those "*switching strategies*" discussed above no longer available starting in 2016. This marked a pivotal opportunity for advisors to make sure clients understand how these changes could impact them. Below is a summary of the recent changes.

The "File and Suspend" Strategy

The "*file and suspend*" strategy, also referred to as "*voluntary suspension*," or "*claim and suspend,*" was an option available to Social Security beneficiaries until April 29, 2016. The key advantage of the "*file and suspend"* strategy was to increase the Social Security claiming options for many married couples by allowing them to take advantage of spousal benefits and "delayed retirement credits" simultaneously. The Bipartisan Budget Act of 2015, passed by Congress and signed by the President in October 2015, ended the possibility of claiming spousal benefits on a suspended benefit for suspension requests made after April 29, 2016.

However, if your client was age 66 or older within the 180 days following the date the bill was enacted (up until April 29, 2016), then they could still "*file-and-suspend.*" But, after April 29, 2016 (approximate date), the "*file-and-suspend*" strategy ceased to exist. It was no longer available to a spouse or dependent on collecting a benefit. Those individuals (claimants) must collect their own benefit and forego DRCs. If an individual (claimant) suspends benefits, all spousal and dependent benefits will be suspended.

After April 29, 2016, the only use of "*file-and-suspend*" will be for those claimants who claimed reduced Social Security benefits before their FRA. They will still be able to suspend benefits to earn DRCs of 8% per year between ages 66 and 70 (see Voluntary Suspension–Withdrawal of Application below). No one will be able to collect spousal or dependent benefits, while the claimant suspends benefits.

Here is the actual text of the new provision added to the Social Security Act, Subsection 202(z), which stipulates that if an individual chooses to suspend benefits, then:

> *"All benefits payable to that individual will be suspended, based on both their own earnings record (i.e., retirement benefits) and also based on any other person's earnings record (i.e., spousal benefits). No other individual will be eligible for benefits based on the earnings record of the person who voluntarily suspends benefits."*

Note: One segment of the population was not able to take advantage of this 6-month window. Same-sex married couples could not file-and-suspend since, to receive spousal benefits, the couple had to have been married for 12 months.

The "Restricted Application" Strategy

The other major change with the passage of the new rules is the elimination of the "*restricted application*" strategies. Section 831(a) of the BBA of 2015, Section 202 (r) (1) of the Social Security Act is altered to expand the "*deemed application*" rules from applying only to early benefits (prior to FRA) to instead applying to all benefits regardless of age.

As you may recall from above, "*deemed filing"* had only been a factor before reaching full retirement age (FRA). Prior to reaching FRA, if a claimant filed for any benefit, they were "*deemed to be filing*" for all benefits. This meant that if a claimant were eligible for their own benefit and a spousal benefit, they would only be paid a single benefit–the equivalent of the higher of the two. If the claimant waited until FRA to claim a benefit, they could choose which benefit to receive (and be allowed to "*switch*" later). If the choice were made to receive a spousal benefit, their own retirement benefit would continue to accrue DRCs.

The new rule extends the "*deemed filing*" provision to age 70, meaning that the payable benefit will always be the higher benefit if eligible for more than one. No longer will an individual (claimant) be able to switch to the other higher benefit (Claim Now and Claim More Later or use the Combination strategy: File & Suspend with a Restricted Application).

Thus, anyone eligible for a spousal benefit is deemed to have filed for their OA retirement benefit. Similarly, anyone eligible for an OA retirement benefit is deemed to have filed for any spousal benefit to which they are entitled. The result is that it will no longer be feasible to file a "*restricted application*" as any retiree who files for one benefit (retirement) is presumed to and deemed to have filed for the other (spousal) benefit as

well–regardless of whether it was/is an early benefit or at full retirement age (exception will be the survivor benefits-discussed below).

However, there was some good news. The new rules around "*restricted application"* apply only to individuals aged 62 any calendar year after 2015. Those individuals who were at full retirement age (or simply who already reached age 62 in 2015, born in 1953 or earlier) will still be able to utilize a "*restricted application"* for spousal benefits only at FRA. Only future retirees–those who turned 62 in 2016 or later, which means those who would have been planning to engage in a restricted application in 2020 or later–will lose access to the "*restricted application*" claiming strategy. Or viewed another way, anyone born in 1953 or earlier is "*grandfathered"* and will still be able to engage in "*restricted application*" in the future (since they remain eligible based on birth year), even if they don't turn age 66 until 2019), while anyone born in 1954 or later will never be able to make a "*restricted application*."

Note: In 2025, there will not be anyone left who could possibly benefit from this restricted filing.

Maximizing Spousal Benefits After BBA of 2015

Both opposite-sex and same-sex married couples are eligible for Social Security spousal and dependent benefits. So are some individuals in legal relationships such as civil unions and domestic partnerships. And those who have been married for at least 10 years and have been divorced for at least two years can also apply.

As we discussed above, the Bipartisan Budget Act (BBA) of 2015 changed the rules on filing for spousal benefits under Social Security, eliminating some popular claiming strategies that once allowed couples to increase their benefits. The new law didn't, however, do away with spousal benefits entirely. If a spouse qualifies, it is still possible to claim benefits based on their spouse's earnings history, even if they never contributed to Social Security themselves.

Spousal benefits, for clarity purposes, will be discussed from the wife's perspective, but the benefits are parallel for the husband—gender neutral. Spousal benefits are those the wife receives based on the husband's earning record while he is alive. The basic rules governing spousal benefits include:

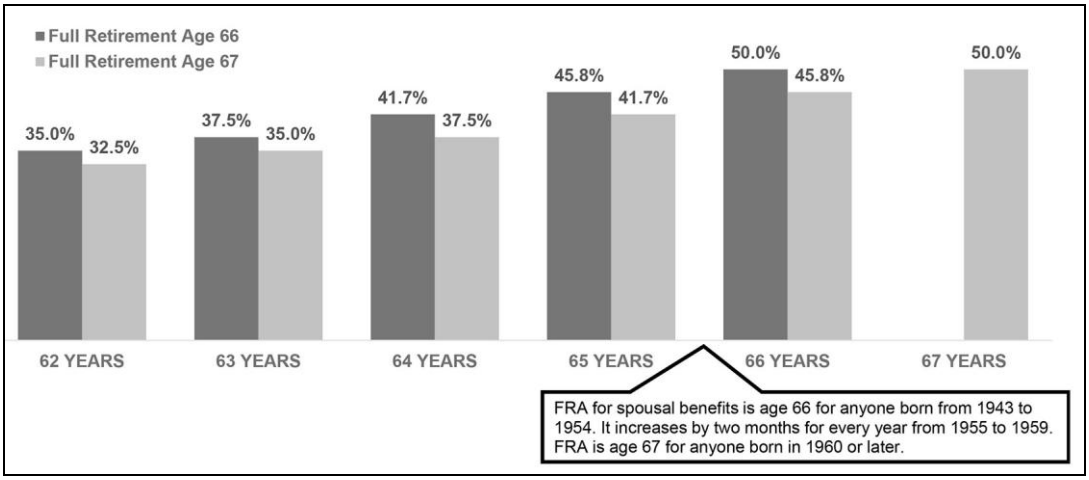
- The husband must be receiving their retirement or disability benefit.
- The wife, applying for spousal benefits, must be at least 62 years old or have a qualifying child – a child who is under age 16 or who receives Social Security disability benefits – in her care.
- Must have been married for at least one year prior to filing for spousal benefits.
- If the wife worked, their spousal benefit at Full Retirement Age (FRA) must be greater than their retirement benefit at Full Retirement Age (FRA).
- Normally a spousal benefit is 50% of the husband's FRA benefit amount, reduced if the wife claims the spousal benefit prior to her FRA. If the wife is already

receiving her own retirement benefits, and later becomes eligible for a spousal benefit, there is a formula (actuarial reduction) that is used to determine what amount of spousal benefit (if any) they may receive (discussed below).

Reminder: The spousal benefit is based on the husband's benefit at his FRA, regardless of whether the husband claimed before, at, or after their FRA. The percentage the wife will receive is based on the age when she applies for or becomes eligible for a spousal benefit.

If the wife chooses to elect to claim a spousal benefit prior to her Full Retirement Age (FRA), the minimum spousal benefit available at age 62 would be 32.5% - 35% of the husband's benefit at his Full Retirement Age (FRA).

Figure 5.3
Spousal Percentages by Age



Case Study

Spouse A's monthly retirement benefit at age 67, Spouse A's FRA as defined by Social Security Administration (SSA), would be $1,000. If Spouse A claimed at age 62, the monthly benefit would be $700. If spouse A claimed at age 70, however, the monthly benefit would be $1,240. The maximum spousal benefit to Spouse B if Spouse B claimed at age 67 (Spouse B's FRA) would be $500 per month, regardless of whether Spouse A applies for the retirement benefit at age 62, 67, or 70. Spouse B's minimum spousal benefit if Spouse B claimed at age 62 would be $325 per month (see Table 5.4)

Table 5.4
Calculating Spousal Benefits
(Case Study)

	Spouse Claims at 62 Receives $700	Spouse A Claims at 67 Receives $1,000	Spouse A Claims at 70 Receives $1,240
Spouse B's spousal benefit at 62[1]	$325	$325	$325
Spouse B's spousal benefit at 67[2]	$500	$500	$500

For illustrative purposes only. Assumes an FRA of 67. Calculations may vary if the amount is different
[1]32.5% of Spouse A's retirement benefit at Spouse A's age 67
[2]50% of Spouse A's retirement benefit at Spouse A's age 67

Reminder: Most people cannot choose which benefit they receive. Generally, the SSA will pay the wife the highest benefit she is eligible to receive at that time. If the husband is already receiving their retirement benefit, the SSA will check the wife's retirement benefit against her spousal benefit and give her the higher of the two benefits. If the husband is not receiving his retirement benefit, the wife's only option is to initially receive her retirement benefit. Then, when the husband applies, the wife may step up to a higher amount if the wife's spousal benefit at FRA is greater than her retirement benefit at her FRA.

Married couples need to coordinate spousal benefits and determine the best age for each spouse to file and receive Social Security benefits. Their objective in coordinating benefits for married couples is to maximize income while both are alive while also providing the highest possible benefits for the survivor, who may live another 25 to 35 years after the death of the spouse. This may result in using different life expectancies for different purposes.

It's also important to remember, even if a spouse is receiving reduced spousal or retirement benefits, they are still eligible for the maximum survivor benefit and will not be subject to the deemed filing rule.

Maximizing Survivor Benefits

For clarity, we present survivors benefits as if the husband dies first, but the rules are parallel if the wife dies first. Survivor benefits (also called widow(er)'s benefits) are those the wife receives on her husband's earnings record after he has died. As explained in Chapter 4 and shown in Table 4.3, the FRA for survivor benefits can differ from the FRA for benefits based on her earnings record or spousal benefits.

Rules for governing survivor benefits include the following:

- Eligibility: To be eligible, the wife must have been married to the deceased husband for at least nine (9) months. There are some exceptions to the rule:
    - The worker died because of an accident.
    - The worker's death occurred in the line of duty while they were a member of a uniformed service or active duty; and
    - The claimant was previously married to the worker, divorced from them, and the previous marriage lasted at least nine months.
- Dual entitlement. The wife, if she is entitled to benefits based on her earnings record or survivor benefits based on the deceased spouse's earnings record.
- She can receive full survivor benefits when she attains FRA for widows or reduced benefits as early as age 60 (age 50 if disabled).
- Her survivor benefit reflects his delayed retirement credit (DRCs) if any.
- If she begins survivor benefits after attaining her FRA for widows, then she is entitled to the larger of:
    - 82.5% of his PIA; or
    - Deceased spouse's monthly benefit amount, where the latter would include any DRCs if he began benefits after his FRA or he died after his FRA and had not started benefits based on his record.
    - If she begins survivor benefits before attaining her FRA for widows, her benefit will be reduced. If she begins at age 60, she will receive 71.5% of his full benefits. If she begins benefits at FRA for widows, she will receive 100% of his full benefits. The younger she starts with benefits, the lower her monthly benefits will be. The reduction varies on a pro-rata basis, with her starting date between FRA for widows and age 60.
- If the deceased spouse did not begin benefits before his FRA, the widow begins survivor benefits before attaining her FRA for widows. Her full widow's benefit (the larger of his PIA or his monthly benefit amount, where the latter includes any delayed retirement credits). If she begins at 60, then she will receive 71.5% of the full widow's benefit. If she begins benefits at FRA for widows, she will receive 100% of the full widow's benefit. The younger she starts survivor benefits, the lower her monthly benefits will be, with the reduction from full widow's benefit varying on a pro-rata basis with her starting date between FRA for widows and age 60.
- If the deceased spouse began benefits before his FRA and the widow begins survivor benefits before attaining, her FRA for widows. In such cases, you need to calculate three amounts:
    - The deceased's retirement insurance benefit (RIB);
    - 82.5% of the deceased's PIA; and
    - The reduced widow insurance benefit (WIB).

  Then these three numbers are aligned from low to high.

Let's review some examples.

Example 1: Husband dies at 64 with a PIA of $2,000, having never begun his benefits. If she chooses survivor benefits when she is 60 (and is not disabled), she will get $1,430 in benefits. If she begins survivor benefit at 62, 64, or 66, she will get $1,620, $1,801, and $2,000 a month with all dollars expressed in today's inflation-adjusted dollars. The 28.5% reduction in the survivor benefit fraction at age 60 is prorated over the 72-month reduction period. In the equation, if her FRA for widow's benefit is 66, then the survivor benefit fraction is 0.715 if she is 60, 0.81 at age 62 [$1,620/$2,000], 0.905 at 64, and 1 if she is FRA for widow's benefits or older. The full-widow's benefit is $2,000.

Example 2: The deceased husband's PIA was $2,000, but he began benefits based on his earnings at age 62. Hence, his monthly benefit level was $1,500. She waits until FRA or later to begin survivor benefits. Her survivor benefit fraction is 1. The full widow's benefit is $1,650, that is, the larger of his monthly benefits [$1,500, of 82.5% of his PIA, [$1,650]. She gets $1,650 in survivors' benefits.

Example 3: The deceased husband began his benefits prior to his FRA, and she begins survivor benefits before her FRA. His PIA was $2,000, but he began benefits based on his earnings at 63, so his monthly benefit level was $1,600. He dies. She wants to begin the widow's benefits at 60. She calculates three amounts:

- the deceased number holder's retirement insurance benefit (deceased's RIB), which is $1,600,
- 82.5% of his PIA, which is $1,650, and
- The reduced widow's insurance benefit (reduced WIB) is $1,430 (71.5% of his PIA, where 71.5% reflects the survivor benefit fraction at age 60). Then these three numbers are aligned from low to high. Her survivor benefit is her reduced WIB of $1,430.

Note: The Bipartisan Budget Act of 2015 (deemed filing rule) will not affect survivor "*switching*" strategies.

Case Study

Let me introduce you to Kim, she is age 60 and was married to Jim prior to his death. Kim is entitled to receive a full survivor benefit of $2.400 per month at age 66 (her Full Retirement Age-FRA) or a reduced survivor benefit of $1,716 per month ($2,400 x .75) at age 60. Kim has also earned her own worker retirement benefit of $1,500 per month at age 62, or $2,000 per month at age 66 (ignoring COLAs).

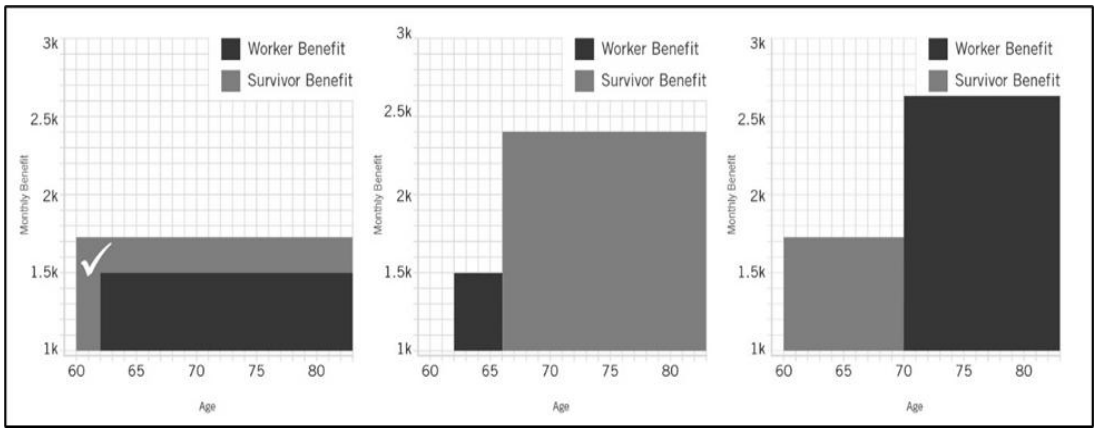
- Using the first strategy (see Figure 5.4). Kim could choose to take the $1,716 reduced survivor benefit at age 60. On the surface, this could be the best option because not only is $1,716 higher than the $1,500 worker benefit Kim is entitled to at age 62, but she can also start it 2 years earlier. However, Kim should consider her other options before deciding.
- With the second strategy (Figure 5.4), Kim could draw her $1,500 worker benefit at age 62, and then switch over to the full survivor benefit of $2,400 at age 66.

If Kim has the resources from other retirement accounts to provide herself with income between the ages of 60 and 62, this method may work very well, since she will ultimately be drawing the higher $2,400 benefit for the rest of her life.

- The third strategy (Figure 5.4) is for Kim to start her survivor benefit at age 60, and then switch over to her worker benefit at age 70, thereby delaying her worker retirement benefit beyond her Full Retirement Age (FRA) and maximizing the Delayed Retirement Credit (DRC) applied to that benefit. She would start the survivor benefit of $1,716 per month at age 60 and then switch to her worker benefit of $2,640 (the $2,000 benefit at Full Retirement Age increased by an annual 8% simple interest Delayed Retirement Credit for 4 years) at age 70. This strategy is the same as the first, except that Kim switches over to a higher benefit at age 70.

Why wouldn't she choose the third strategy, as opposed to the first one? The answer is likely that she wouldn't choose this strategy only because she is unaware that this option is available to her. This case study is not just to imply that the third strategy is always the best. Any "optimal strategy" depends on the size of the widow(er)s own worker retirement benefit and the survivor benefit, as well as the individual's own health and financial situation.

Figure 5.5
What Widows and Widowers Approaching Retirement Need to Know About Claiming Social Security Benefits



Claim the benefit with the greatest monthly value when you initially file.

Claim the worker benefit at age 62 and switch to the survivor benefit at Full Retirement Age (66).

Claim the survivor benefit at age 60 and switch to the worker benefit at age 70.

Voluntary Suspension of Retirement Benefit

The original rule allowing for voluntary suspension (also known as the "*Reset*" strategy) of an individual's retirement benefits remains in place. The rule exists for those who started retirement benefits early (prior to FRA), who now have "changed their mind" and wish to delay Social Security benefits and earn DRCs. This strategy had gained a lot of attention in previous years, thanks in part to a series of articles that unveiled several ways of making the most of Social Security benefits.

Withdrawal of Application

On December 8, 2010, the SSA issued its new regulation on the "*withdrawal of application" (*Section 404.640) and the use of the "*Reset*" strategy to limit the withdrawal of OA retirement benefits. Under this new regulation, which became effective as of December 8, 2010 (no grandfathering), Social Security recipients would be allowed to withdraw their application for Social Security benefits only once during their lifetime and only within 12 months of the first month of entitlement. According to SSA, this 12-month limitation will allow flexibility for beneficiaries who experience an unexpected change in circumstances during that time. In addition, limiting the period for application withdrawals to within 12 months of the first month of entitlement will minimize the likelihood of abuse and the potential harm to the trust funds.

If an individual decided to collect early just because they could but later regrets their decision and wished they had held out for a bigger monthly check, they were allowed to file SSA Form 521 ("Request for Withdrawal " Application") at their local Social Security office. Once filed, their Social Security retirement benefits would stop almost immediately. If they were married and their spouse received benefits based on their work record, their benefits would stop. Then the Social Security Administration would send the individual a letter telling them how much they needed to repay (including any spousal benefits). That process may have taken several weeks or even months. Once the individual repaid the benefits–which can top $100,000–they could have reapplied for a higher payment based on their current age, locking in a larger base amount for future cost-of-living adjustments and maximizing lifetime benefits for a surviving spouse. Sounds like a rather good strategy.

Suspension of Benefits

In addition, the rule also allowed those who have reached their FRA to suspend benefits (do not have to pay back any funds to SSA, and there is no time limit). If an individual has reached their FRA but is not yet 70, they can request SSA to suspend their retirement benefits beginning the month after the month they submit their request. SSA pays benefits the month after they are due. So, if the individual contacts SSA in January and requests that they suspend their benefit, they will receive their January benefit in February. The suspension will begin after that.

Although the individual's Social Security benefits will stop during the suspension period, they will earn DRCs worth 8% per year, for each year they postponed benefits between FRA and age 70. If benefit payments are suspended, they will automatically start the month the individual reaches age 70.

In addition, effective April 30, 2016:

- Under the new rules, individuals will not be able to backdate an application and receive a lump sum. Nor will any individual be able to receive any lump sum for retroactive payments. According to the legislation, Section 202(z):
    - *"In the case of an individual who requests that such benefits be suspended under this subsection, for any month during the period in which the suspension is in effect–(A) no retroactive benefits (as defined in subsection (j)(4)(B)(iii)) shall be payable to such individual;"*
- If an individual voluntarily suspends their retirement benefit and has others who receive benefits on their record, they will not receive benefits for the same period that their benefits are suspended. There is one exception, divorced spouses will be able to continue receiving benefits.
- If an individual voluntarily suspends their retirement benefit, any benefits they receive on someone else's record will also be suspended. The individual's Part B premiums cannot be deducted from their suspended benefits; and
- If an individual requests voluntary suspension on or after April 30, 2016, SSA will only permit benefit reinstatement beginning the month after the month of their request.

In addition, there are some other things you need to know about what will happen if an individual suspends their retirement benefits:

- If the individual is enrolled in Medicare Part B (Supplementary Medical Insurance), they will be billed by the Centers for Medicare & Medicaid Services (CMS) for future Part B premiums.

These premiums cannot be deducted from the suspended retirement benefits or a suspended spouse or ex-spouse's benefits. If the individual does not pay the premiums in a timely manner, they may lose their Part B Medicare coverage. The individual can have the option of automatically paying the bill from an account at their bank or financial institution.

Divorced Spouse Benefits

A divorced spouse may be entitled to Social Security benefits based on retirement (OA), survivor (S), and disability (DI) benefits. Each benefit has its separate rules. And because of the Bipartisan Budget Act of 2015, there are now two sets of rules that apply to claiming strategies for divorced spouses. Before we discuss the changes, let's review the basic rules of how a divorced spouse becomes eligible for Social Security benefits.

Eligibility Rules for Divorced Spouses

A divorced spouse may claim a spousal benefit under their ex-spouse's record if the ex-spouse is "*eligible*" to receive either their worker's OA retirement benefit or disability benefit through Social Security. In addition, the divorced spouse must fulfill the following requirements:

- Be at least 62 years old.
- Be divorced from the ex-spouse who receives Social Security retirement or disability benefits.
- Have been married to the ex-spouse for at least ten years before the date the divorce became final.
- Be unmarried; and
- Not be eligible for an equal or higher benefit based on their own work or someone else's work.

Unlike married couples, a divorced spouse may be eligible for spousal benefits as an "*Independent Entitled Divorced Spouse*" ("IEDS") based on his/her ex-spouse's record while that ex-spouse is still living when the ex-spouse is entitled to his or her own benefit but has not yet filed for them.

The criteria for an individual to receive spousal benefits as an IEDS includes:

- The parties must have been married for *a minimum of ten* years.
- The applicant must be at least age 62.
- The applicant must be *unmarried*; and
- If the ex-spouse is entitled to his or her benefits and has not filed for those benefits, the applicant has waited a minimum of TWO YEARS from the date of the divorce.

Once the above criteria are met, the next step in determining whether an individual will qualify for divorced spousal benefit depends on whether the divorced spouse's PIA is *less than 50% of* the PIA of the ex-spouse. If that is the case, then the "base spousal benefit" received will be the value to get the divorced spouse to the *one-half* value of the ex-spouse's PIA.

If a divorced spouse meets all the above requirements, they can file for a spousal benefit under their divorced ex-spouse's record. The divorced ex-spouse doesn't need to contact their ex-spouse to notify them of their filing, nor do they need their ex-spouse's Social Security statements to determine their spousal benefit.

In some cases, a divorced spouse can file a "*restricted application*" for spousal benefits only, allowing them to collect spousal benefits while their own retirement benefit continues to grow by the 8% delayed retirement credits (DRCs) until age 70.

However, as was discussed above, after the enactment of the Bipartisan Budget Act of 2015, only those people who were born on or before January 1, 1954, are eligible to restrict their claim to spousal benefits when they turn 66 and allow their own retirement benefits to grow up until age 70. Divorced spouses who are still eligible to choose which benefit to claim can each file a restricted application for spousal benefits on the other's earnings record at 66. Married couples can't do that. Only one spouse in a marriage can claim spousal benefits.

Younger married and divorced spouses will never have the option of choosing which benefits to claim because of the newly deemed filing rules under the Bipartisan Budget Act of 2015. People born on or after January 2, 1954, will be deemed to file for all available benefits–both spousal and their own retirement benefit–when they claim Social Security, and will be paid the higher of the two benefits.

There is one more rule change to keep in mind for divorced clients. Under the new rules, workers who claim reduced Social Security benefits early can still suspend benefits at full retirement age (FRA) to earn DRCs. Normally that means any auxiliary benefits for a spouse or eligible minor dependent child, or permanently disabled child would also stop during the suspension. Suspending benefits does not affect the benefits of an ex-spouse.

Divorced Spouse Survivor Benefits

A divorced spouse is entitled to survivor benefits on the work record of an ex-spouse if all of the following requirements are met:

- The marriage lasted at least 10 years.
- You are at least 60 years old (50 if you are disabled) or caring for a child from the marriage who is under 16 or disabled. (In the latter circumstance there is no minimum age for you to claim survivor benefits.)
- Divorced spouse is single or, if remarried, did so after turning 60 (50 if disabled). If the divorced spouse remarries before that age and is still with that spouse, the divorced spouse cannot claim survivor benefits on the record of the ex-spouse's work record.

As with widow(er)s, waiting until reaching full retirement age (FRA) for survivors entitles the divorced spouse to receive 100 percent of the amount the deceased ex-spouse was getting from Social Security when he or she died. (If the deceased never claimed benefits, the divorced spouse will get what he or she was eligible to receive.) In most cases, claiming survivor benefits before reaching full retirement age (FRA)reduces the amount of your benefit.

Keep in mind. The deemed filing rule does not apply to survivor benefits. So, if an eligible divorced spouse had not yet claimed Social Security and her divorced ex-spouse died, the divorced spouse could claim survivor benefits first and switch to their own maximum retirement benefits at 70. Or, depending on their age at the time of the ex-spouse's death, they might be able to claim their own reduced retirement.

Further Reading

Center for Retirement Research at Boston College; *Accounting for Social Security Claiming Behavior, September 2018*; https://crr.bc.edu/working-papers/accounting-for-social-security-claiming-behavior-2/

Social Security Administration, *When to Start Receiving Retirement Benefits*; https://www.ssa.gov/pubs/EN-05-10147.pdf

Stanford Center of Longevity, "*Understanding Longevity: An Important Life Planning Step*," http://longevity.stanford.edu/working-longer-retirement/wp-content/uploads/sites/9/2017/02/Understanding-Longevity.pdf

Social Security Administration, Benefits Planner, "*If You Are Divorced*," https://www.ssa.gov/planners/retire/divspouse.html

Social Security Administration, Benefits Planner, "*If You Are the Survivor*" https://www.ssa.gov/planners/survivors/ifyou.html

Congress.Gov, H.R. 1314–Bipartisan Budget Act of 2015; https://www.congress.gov/bill/114th-congress/house-bill/1314/text#toc-H42AB7F5BEC284309AB1FAE1A826CFB21

Chapter 5
Review Questions

1. Electing to begin to take OA retirement benefits at age 62 may permanently reduce the amount of the monthly benefit (depending on their FRA) by what percent?

( ) A. 10%–15%
( ) B. 15%–20%
( ) C. 25%–30%
( ) D. 35%–50%

2. Spousal benefits may provide up to what percent of the other working spouse's primary insurance amount (PIA)?

( ) A. 100%
( ) B. 25%
( ) C. 30%
( ) D. 50%

3. Under the Bipartisan Budget Act of 2015, the "*deemed filing*" rule will be extended to what age?

( ) A. 67
( ) B. 66
( ) C. 70
( ) D. 62

4. A non-disabled widow(er) may begin to receive survivor benefits beginning at what age?

( ) A. 60
( ) B. 62
( ) C. 50
( ) D. 66

5. For a divorced spouse to be eligible to receive "spousal benefits" based on the ex-spouse's work record, they had to have been married for how many years before the date of the divorce became final?

( ) A. 9 months
( ) B. 2 years
( ) C. 10 years
( ) D. 1 year

CHAPTER 6

WOMEN AND SOCIAL SECURITY

Overview

Social Security provides a critical income source for women, especially older women. It is an especially important income source for older women. Women are less likely to have other sources of retirement income, such as pensions and savings, making Social Security one of their few sources of retirement income. Moreover, three key features of the Social Security program–progressivity of the benefit formula, guaranteed benefits for life, and inflation-adjusted benefits–are particularly beneficial to women.

For millions of women who rely heavily on Social Security income, the monthly benefit amount can mean the difference between making ends meet and sliding into poverty. Learning the rules and regulations of Social Security is the first step women must take to prepare for retirement.

This chapter will review the importance of Social Security to women and the various benefits made available to them.

Learning Objectives

Upon completion of this chapter, you will be able to:

- Realize the importance of Social Security (OASDI) benefits to women.
- Review the facts and figures about Social Security (OASDI) benefits and women.
- Identify the various OASDI benefits available to women.
- Utilize several proposals to help women increase their Social Security benefits; and
- Determine how the Chained CPI will affect women's Social Security benefits.

Background

The fact that women live longer than men is ubiquitous. Across the industrialized world, women still live 5 to 10 years longer than men. Among people over 100 years old, 85% are women, according to Tom Perl, founder of the New England Centenarian Study at Boston University and creator of the website www.*LivingTo100.com*.

According to the World Economic Forum, women outlive men in all countries, without exception. So why is this? There are many theories. Here are some of the top ones, according to many researchers:

- The first is biology. Estrogen helps protect longevity by increasing the good kind of cholesterol, while testosterone hurts men's longevity by increasing the bad kind of cholesterol. Also, while women are more likely to have diseases, the diseases we get are less deadly than men's diseases.
- Women are more health-conscious, which leads to quicker diagnoses and treatment than men.
- Finally, women generally overestimate risk, and men generally underestimate risk. As a result, women tend to be more risk-averse than men.

This longevity has led to women being most adult beneficiaries, collecting Social Security as retired or disabled workers, and wives and widows. According to SSA, as of December 2024 women make up 55.1 percent of Social Security beneficiaries aged 62 and older and 62.3 percent of beneficiaries aged 85 and older (see Table 6.1)

Table 6.1
Social Security Beneficiaries aged 62 and Over
End of December 2024 (number in thousands)

		Men		Women	
Age Group	**Total**	**Number**	**Percent**	**Number**	**Percent**
62 – 69	19,056	8,703	45.7	10,354	54.3
70 – 84	34,436	15,732	45.7	18,704	54.3
85 & over	6,110	2,304	37.7	3,806	62.3
Total age 62 & over	59,602	26,739	44.9	32,863	55.1

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Note: Excludes adults who became disabled as children.
Totals do not necessarily equal the sum of rounded components.
Source: SSA, https://www.ssa.gov/OACT/ProgData/byage.html

Here are some additional facts from The National Women's Law Center, "*Women and Social Security*" to consider:

- Key Facts
  - Nearly two in three Social Security beneficiaries 65 and older are women.
  - Social Security is virtually the only source of income for more than one in four female beneficiaries 65 and older.
  - Without Social Security, more than two in five women 65 and older would have been poor in 2017.
- Most Social Security beneficiaries are women.
  - Women made up over 55% of Social Security beneficiaries 62 and older and 63 percent of beneficiaries aged 85 and older.
- Social Security benefits are lower for women than for men.

    - The average Social Security benefit for women 65 and older is about $14,270 per year, compared to $18,375 for men 65 and older.
- Women rely even more on income from Social Security than men do.
    - On average, women beneficiaries 65 and older receive 58 percent of their family income from Social Security, compared to 53 percent for men beneficiaries 65 and older.
    - For more than one in four women beneficiaries 65 and older (27 percent), Social Security is virtually the only source of income (90 percent or more). Just over two in ten men beneficiaries 65 and older (21 percent) rely on Social Security for 90 percent or more of their income.
    - The percentage of women beneficiaries who rely on Social Security for virtually all of their income increases sharply with age: from about 20 percent for women 65-69 to 36 percent for women 80 and older. Men beneficiaries' reliance on Social Security also increases with age, but to a lesser extent: from 16 percent for men 65-69 to 28 percent for men 80 and older.
- Social Security income is particularly important to unmarried women.
    - On average, unmarried women beneficiaries 65 and older, including beneficiaries who are widowed, divorced, or never married, receive 63 percent of their family income from Social Security, compared to 53 percent of married women beneficiaries.
    - For 34 percent of unmarried women beneficiaries 65 and older, Social Security is virtually the only source of income (90 percent or more), compared to 20 percent of married women beneficiaries 65 and older.
- Social Security is a key anti-poverty program for older women, who are more likely than older men to fall below the poverty line.
    - Social Security is a critical anti-poverty program for women and their families.
    - In 2021, women made up more than six in ten people aged 65 and older (61%) who lived in poverty. The official poverty rate for women 65 and older was 11.6% in 2021, compared to 8.8% for older men.
    - Women aged 80 and older had the highest poverty rate (14.7%) among older persons in all age groups.
    - Elder women who are not married are more likely than married older women to live in poverty. Among women aged 65 and older, about 16% of widows, 17% of divorced women, and nearly 20% of never-married women had incomes below the official poverty line compared with 5.8% of married women.
    - Social Security has proven successful in protecting millions of older women from falling into poverty. In 2021, Social Security lifted 18.1 million people aged 65 and older out of poverty as measured by the Supplemental Poverty Measure, of whom 10.4 million were older women compared to 7.7 million older men.
- Despite Social Security, older women remain at greater risk of poverty than older men.
    - More than one in eight women (13.2 percent) aged 75 or older live in poverty, compared with 8.8 percent of men.

- The poverty rate for women 65 and older was 11 percent, compared to 8 percent for men 65 and older.
- The poverty rate for women 65 and older living alone was 18 percent, compared to 15 percent for men 65 and older living alone.
- Poverty rates were particularly high, at about one in five, for Black (22 percent) and Latina (19 percent), and Native (19 percent) women 65 and older.
- In 2021, Social Security lifted 10.4 million women aged 65 and over out of poverty as measured by the Supplemental Poverty Measure, including nearly 1.3 million older Black women, 885,000 older Latinas, and 329,000 older Asian women.

Next, let's review the various Social Security (OASDI) benefits a woman can qualify for and the amounts she receives compared to men.

Social Security Benefits for Women

Women are generally eligible for one of four types of OASDI benefits:

- Retired worker's benefit.
- Spousal benefit is based on the husband's (or former husband's) benefit.
- Survivor benefit; or
- Disability benefit.

Women's Own Retired Worker Benefits

In theory, Social Security is set up to pay the same retired worker benefits to adults with the same work histories and earnings (gender-neutral). That said, many women are eligible for a retired worker benefit based on their own work histories. As was discussed above, the reality is that women don't typically have the same work histories and earnings as men, so their retired worker benefits are usually lower. In fact, women often work fewer than the 35 years on which the full benefit is based. That is why women retiring today average *13 years of zeroes***.** All of this adds up to a major gender gap in retirement benefits.

According to SSA, as of May 2025, a man's average monthly retired worker's benefit was $2,208.47 or $26,501.64 a year vs. the average monthly retired worker's benefit for a woman of $1,807.49 or $21,689.88 a year. That is a yearly difference of $4,811.76 less for women.

If you want to know how much that difference adds up over the course of a retirement, consider this: During a 20-year retirement, the average man will receive about $85,000 more in Social Security benefits than the average woman. Over 30 years, the difference is more than $127,000.

Why the difference? Well, you don't need an economics degree to figure out why: It's because women have consistently earned less than men over the decades — and that pay gap still exists. In 2025, for every $1 that men make, women earn $0.83 when data are uncontrolled, according to the Society for Human Resource Management, which cited research from Payscale's 2025 State of the Gender Pay Gap Report. This is one cent nearer to closing the gender pay gap compared to last year.

Women are also much more likely than men to leave the workforce to care for children. The result is that they don't earn nearly as much money as men over the course of their professional lives. This has a major impact on their Social Security retirement benefits, which are based on income during 35 highest earning. When someone drops out of the workforce for a substantial number of years, those zero-income years are factored into the benefit calculation, which shrinks checks even more.

There have been some encouraging developments, however. The Social Security gender gap has been slowly narrowing over the last few decades as the gender pay gap shrinks as well. As reported in the 2025 Gender Pay Gap Report, the controlled gender pay is $0.99 for every $1 men make, which is still not equal. The controlled pay gap tells us what women earn compared to men when all compensable factors are accounted for — such as job title, education, experience, industry, job level, and hours worked. Although $0.99 cents may seem very close to $1, small differences in earnings on the dollar can compound over the course of a lifetime career. The gender pay gap should be zero. It is not zero.

In other words, women who are doing the same job as a man, with the exact same qualifications as a man, are still paid less than men for no attributable reason, year over year. There is not equal pay for equal work.

Next, let's examine how women can benefit from spousal benefits.

Spousal Benefits

If a married or divorced woman earns a benefit that is less than 50 percent of the amount her spousal benefit would be, or if she has no benefit from her own work years, she is eligible for a spousal benefit. This benefit is generally equal to half of her husband's (or former husband's) worker benefit at her FRA. Until recently, the spousal benefit was the most common type of benefit received by older women.

A divorced woman is also eligible for spousal benefits, but only if her marriage lasted at least 10 years, she remains unmarried and is at least age 62. This benefit does not affect the benefits of a divorced woman's former husband or his current spouse if he remarries.
If the divorced woman earned benefits through her own work history as well as through spousal eligibility, she is "dually entitled." This doesn't mean she will get both benefits added together. If she qualifies for more than one benefit, she will receive a higher benefit amount.

According to SSA, as of May 2025, 1,850,752 million women spouses were receiving an average monthly spousal benefit of $969.54 per month. While at the same time, male spouses of a retired worker totaled 143,887, receiving an average monthly benefit of $701.42.

Survivor (Widow) Benefits

According to SSA, as of May 2025, nondisabled aged widows (3.479 million) make up most survivor benefit recipients (95 percent) who are all age 60 and older and, on average, were receiving a monthly survivor benefit check of $1,876, or $22,512 a year.

According to SSA, as of May 2025, nondisabled young widows with child numbered 91,207 representing 92% of total young widow(er)s of 99,150. Young widows receive an average monthly benefit payment of $1,328.18, or $15,938.16 a year. Compared to male widowers of 7,952 receiving a monthly benefit of $1,152.95 or $13,835.40 a year.

If a woman is divorced and her former husband worked long enough to earn a Social Security retirement benefit, she may be eligible for a survivor benefit if their marriage lasted at least 10 years and she is at least age 60 (50 if she is disabled). If she has been receiving benefits as a survivor and reaches full retirement age (FRA), she can switch to her own retired worker benefit if it is larger.

Social Security Fact Sheet on Women

The Social Security Administration provides this Fact Sheet to highlight how women benefit from the Social Security (OASDI) programs and how certain demographic characteristics of women compared with the entire population.

- With longer life expectancies than men, older women tend to live more years in retirement and have a greater chance of exhausting other sources of income. They benefit from Social Security's cost-of-living protections because benefits are annually adjusted for inflation:
    - Women reaching age 65 in 2025 are expected to live, on average, an additional 21.1 years compared with 18. years for men.
    - Women represent 55.2 percent of all Social Security beneficiaries aged 60 and older and approximately 63.3 percent of beneficiaries aged 85 and older.
- The Social Security System is progressive. Lower-wage earners receive a higher percentage benefit than higher-wage earners do. The system returns a greater percentage of pre-retirement earnings to a lower-wage worker than to a higher-wage worker. Women who are low-wage workers receive back more benefits in relation to past earnings than do high-wage earners: and
    - In 2021, the median earnings for women aged 15-64 who worked full-time, year-round were $50,000, compared to $60,000 for men.
- In 2022, the average annual Social Security income received by women 65 years and older was $14,824, compared to $18,910 for men. Social Security provides

dependent benefits to spouses, divorced spouses, elderly widows, and widows with young children:
- In 2023, women generally receive lower pension benefits due to their relatively lower earnings and a higher share of part-time workers are women (64 percent).

Note: This fact sheet (latest update September 2024) is designed to provide general information and does not apply to all individuals within the female population. For additional information of interest to women, visit the SSA website at: https://www.ssa.gov/news/press/factsheets/women-alt.pdf

Notifying SSA of Name Changes

If your client changes her name on her account records, you should make sure she also reports the name change to the Social Security Administration (SSA). Otherwise, her earnings may not be recorded properly, and she may not receive all the benefits she is due. Not changing her name with Social Security also can delay her income tax refund.

To report a name change, she would need to fill out an Application for a Social Security Card (Form SS-5). She can get the form by visiting www.socialsecurity.gov on the Internet or any Social Security office or calling Social Security's toll-free number, 800-772-1213.

She must show SSA her most recently issued document as proof of her legal name change. Documents Social Security may accept to prove a legal name change include:

- Marriage document.
- Divorce decree.
- Certificate of Naturalization showing a new name; or
- Court order for a name change.

If the document your client provides as evidence of a legal name change does not give SSA enough information to identify her in their records, or if she changed her name more than two years ago (four years ago if she is younger than age 18), she must show SSA an identity document in her old name (as shown in SSA records). SSA will accept an identity document in her old name that has expired.

If she does not have an identity document in her old name, SSA may accept an unexpired identity document in her new name, if SSA can properly establish her identity in their records. If she is a U.S. citizen born outside the United States and SSA records do not show her as a citizen, she will need to prove her U.S. citizenship. If she is not a U.S. citizen, SSA will ask to see her current immigration documents. The new card will have the same number as her previous card but will show her new name.

Proposals to Benefit Women

Several Social Security reform proposals are intended to benefit women. An enhanced minimum benefit targeting workers with long careers and low lifetime earnings would benefit low-income women. An enhanced minimum benefit would ensure that workers receive a minimum level of benefits regardless of their lifetime earnings. This proposal is particularly effective at targeting never married and divorced women with low lifetime earnings but enough years of covered employment to be eligible for Social Security.

Caregiving credits are often proposed in addition to an enhanced minimum benefit. This proposal would treat time spent out of the labor force providing unpaid caregiving as time spent working for the purposes of Social Security benefit calculation. Caregiving credits would be beneficial to people of any marital status who spend time out of the labor force to care for children–and since women are more likely to be caregivers, this proposal is particularly targeted to them.

Other proposals target married and divorced women. Some proposals suggest tying the survivor benefit to the couple's combined earnings rather than the deceased worker's earnings. An increased survivor benefit would help women with significant work histories who would otherwise experience a decrease in income after the death of their spouse. Decreasing the number of years of marriage required for divorced spouses to be eligible for spouse benefits may be a way to target the higher poverty rates of divorced women, who are less likely to have any Social Security income than married and widowed women.

While Social Security benefits provide women with critical retirement income, further reforms could do even more to reduce pockets of poverty among older women. Older minority women, never-married women, and divorced women are more likely to be in poverty and less likely to receive Social Security.

Effects of the Chained CPI on Women

In an article written by the National Women's Law Center back in June 2011, "*Cutting the Social Security COLA By Changing the Way Inflation Is Calculated Would Especially Hurt Women,*" the authors write:

> *"Shifting to the Chained CPI would mean a cut in Social Security benefits for current and future beneficiaries, compared to the benefits they would receive under the current COLA. The cut would grow deeper the longer an individual received benefits, making this cut especially painful for women who have longer life expectancies, rely more on income from Social Security, and are already more economically vulnerable than men."*

The impact of a COLA reduction compounds over time: the longer an individual receives benefits, the deeper the cut. Long-term beneficiaries–the oldest and individuals who

become disabled at an early age–would experience the deepest percentage cuts from shifting to the Chained CPI.

Table 6.2 shows the effect that reducing the COLA by adopting the Chained CPI would have on monthly Social Security benefits compared to current law. The application of the COLA starts at the early eligibility age, age 62, regardless of when benefits are claimed, and reduces benefits by roughly 0.3 percent per year compared to current law. Thus, as Table 6.2 demonstrates, though the cuts begin relatively small–at age 65, monthly benefits are less than 1 percent lower under the Chained CPI than under current law–the cuts from the reduced COLA add up each year. At age 95, monthly benefits would be almost 10 percent lower than under current law.

Table 6.2
Percent Cut in Monthly Benefit from Chained CPI, Compared to Current-Law Benefits

Age of Beneficiary	Monthly Benefit % Decreases
65	-0.90%
70	-2.30%
75	-3.75%
80	-5.10%
85	-6.50%
90	-7.90%
95	-9.20%

Source: NWLC calculations based on Office of the Chief Actuary's Memo, December 1, 2010; NWLC June 2011,
"Cutting The Social Security COLA By Changing The Way Inflation Is Calculated Would Especially Hurt Women,

Further Reading

Social Security Fact Sheet: Social Security Is Important to Women (updated September 2023) https://www.ssa.gov/news/press/factsheets/women-alt.pdf

Social Security Administration, *Why Social Security Is Important to Women*; https://blog.ssa.gov/why-social-security-retirement-is-important-to-woman/

Social Security Administration, *What Every Women Should Know*; SSA Publication No. 05-10127 June 2017, ICN 480067; https://www.ssa.gov/pubs/EN-05-10127.pdf

Social Security Website for Women; https://www.ssa.gov/people/women/

AARP, Social Security: *A Lifetime for Older Women and Minorities*; https://www.aarp.org/content/dam/aarp/ppi/2018/08/social-security-a-lifeline-for-older-women-and-minorities.pdf

The National Women's Law Center, Women and Social Security (July 14, 2023); Social Security Is Vital To Older Women's Financial Security
Social Security is Vital to Older Women's Financial Security - National Women's Law Center (nwlc.org)

2025 Gender Pay Gap Report
https://www.payscale.com/research-and-insights/gender-pay-gap/

Social Security Fact Sheet: Social Security Is Important to Women (updated September 2024) https://www.ssa.gov/news/press/factsheets/women-alt.pdf

Chapter 6
Review Questions

1. As of December 2024, women represent what percent of all OASDI beneficiaries age 62 and older?

( ) A. 25.5%
( ) B. 33.0%
( ) C. 15.5%
( ) D. 55.1%

2. Women retiring today average how many years of zeroes on their working history?

( ) A. 5 years
( ) B. 13 years
( ) C. 7 years
( ) D. 15 years

3. According to the Society for Human Resource Management, which cited research from Payscale's 2025 State of the Gender Pay Gap, for every $1 that men make, women earn what amount when data is uncontrolled?

( ) A. $0.53
( ) B. $0.83
( ) C. $0.97
( ) D. $0.77

4. A spouse who is disabled can begin to receive survivor benefits beginning at what age?

( ) A. 60
( ) B. 62
( ) C. 50
( ) D. 55

5. It is estimated that under the Chained CPI, the monthly retirement benefit at age 95 under current law could be reduced by what percent?

( ) A. 10%
( ) B. 15%
( ) C. 5%
( ) D. 25%

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CHAPTER 7

TAXATION OF SOCIAL SECURITY BENEFITS

Overview

In 1983, to build up the Social Security system, Congress passed a series of amendments that contained tax provisions to begin taxing Social Security payments. The objective was to take away part of the Social Security benefits for high-income beneficiaries who did not need that income by imposing a tax on their Social Security benefits (means-testing). However, since the income thresholds used in the calculation were never indexed for inflation, many moderate-income beneficiaries now pay taxes on their Social Security benefits.

This chapter will review the background of the legislation that enacted the laws to tax Social Security benefits, their various rules, how to calculate the tax, and some planning options to avoid the taxation of Social Security benefits.

Learning Objectives

Upon completion of this chapter, you will be able to:

- Review the intent and purpose of the "surtax" on Social Security benefits.
- Identify and calculate "provisional income."
- Describe Modified Adjusted Gross Income (MAGI).
- Calculate the "surtax" on Social Security benefits.
- Determine ways to avoid the "surtax" on Social Security benefits; and
- Understand the various state tax laws concerning Social Security benefits.

History of Taxing Social Security Benefits

Until 1984, Social Security benefits were exempt from the federal income tax. The exclusion was based on rulings made in 1938 and 1941 by the Department of the Treasury, Bureau of Internal Revenue (the predecessor of the Internal Revenue Service). The 1941 Bureau ruling on Social Security payments viewed benefits as being for general welfare. It is reasoned that subjecting the payments to income taxation would be contrary to the purposes of Social Security.

Under these rules, the treatment of Social Security benefits was like that of certain types of government transfer payments (such as Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), and benefits under the Black Lung. Benefits Act). This was in sharp contrast to then-current rules for retirement benefits under private pension systems. Benefits from those pension plans were fully taxable, except for the portion of total lifetime benefits (using projected life expectancy) attributable to the employee's own contributions to the system (and on which they had already paid income tax).

Currently, (and as in 1941), under Social Security, the worker's contribution to the system is half of the payroll tax, officially known as the Federal Insurance Contributions Act (FICA) tax. The amount the worker pays into the Social Security system in FICA taxes is not subtracted to determine income subject to the federal income tax and is therefore taxed. The employer's contributions to the system are not considered part of the employee's gross income. They are deductible from the employer's business income as a business expense. Consequently, neither the employee nor the employer pays taxes on the employer's contribution.

The 1979 Advisory Council on Social Security concluded that because Social Security benefits are based on earnings in covered employment, the 1941 ruling was wrong. The tax treatment of private pensions was a more appropriate model for the tax treatment of Social Security benefits. The council estimated that most anyone who entered the workforce in 1979 would pay payroll taxes during their lifetime would equal 17% of the Social Security benefits they would ultimately receive. This was the most any individual would pay; in the aggregate, workers would make payroll tax payments amounting to substantially less than 17% of their ultimate benefits. Because of the administrative difficulties involved in determining the taxable amount of each benefit and avoiding "taxing more of the benefit than most people would consider appropriate," the council recommended instead that half of everyone's benefit be taxed. They justified this ratio as a matter of "rough justice." They noted that it coincided with the portion of the tax (the employer's share) on which income taxes had not been paid. This position to tax Social Security benefits contrasted with the National Commission on Social Security, established by Congress in the Social Security Amendments of 1977 (P.L. 95-216). In its 1981 final report, the commission did not include a recommendation to tax Social Security benefits.

The National Commission on Social Security Reform (often referred to as the "Greenspan Commission"), appointed by President Ronald Reagan in 1981, recommended in its 1983 report that, beginning in 1984, 50% of Social Security cash benefits and Railroad Retirement Tier 1 benefits be taxable for individuals whose adjusted gross income (AGI), excluding Social Security benefits, exceeded $20,000 for a single taxpayer and $25,000 for a married couple, with the proceeds of such taxation credited to the Social Security Trust Funds. The commission did not include any provisions for indexing the thresholds.

The commission estimated that 10% of Social Security beneficiaries would be subject to taxation of benefits. The commission acknowledged that the proposal had a "notch" problem, in that people with income at the thresholds would pay significantly higher taxes than those with only one dollar less but trusted that it would be rectified during the legislation process.

In enacting the 1983 Social Security Amendments (P.L. 98-21), Congress adopted the commission's recommendation to tax Social Security benefits, but with a formula that gradually increased the taxable share as a person's income rose above the thresholds, up to a maximum of 50% of benefits. The formula calculated taxable benefits as the lesser of 50% of benefits or 50% of the excess of the taxpayer's "*provisional income*" over thresholds of $25,000 (for single filers) and $32,000 (for married filers). Provisional income equals adjusted gross income (AGI) plus tax-exempt interest plus certain income exclusions plus 50% of Social Security benefits. In 1993, the Social Security Administration's Office of the Actuary estimated that, if pension tax rules were applied to Social Security, the ratio of total employee Social Security payroll taxes to expected benefits for current recipients (in 1993) would be approximately 4% to 5%. The actuarial estimates were (for workers just entering the workforce in 1993) 15%.

Applying tax rules for private and public pensions presents practical administrative problems. Determining the proper exclusion would be complex for several reasons, including the difficulty of calculating the ratio of contributions to benefits for each individual when several people may receive benefits based on the same worker's account.

President Clinton proposed (as part of his FY 1994 budget proposal) that the portion of Social Security benefits subject to taxation be increased from 50% to 85%, effective in the tax year 1994. Under then-current law, only Social Security recipients whose provisional income exceeded the thresholds of $25,000 (for single filers) and $32,000 (for married filers) could pay taxes on their benefits. Also, under the current law, the first step was to add 50%, not 85%, of benefits to adjusted gross income. Because the thresholds and definition of provisional income did not change, the measure would only affect recipients already paying taxes on benefits. However, the ratio used to compute taxable benefits increased from 50% to 85%. Taxing no more than 85% of Social Security benefits (the estimated portion not based on contributions by a recipient, including highly paid males) would ensure that no one would have a higher percentage of Social Security benefits subject to tax than if the tax treatment of private and civil service pensions were applied.

The proceeds from the increase (from 50% to 85%) were slated to be credited to the Medicare Hospital Insurance (HI) program, which had a less favorable financial outlook than Social Security—doing so also avoided possible procedural obstacles (budget points of order that can be raised regarding changes to the Social Security program in the budget reconciliation process). This measure was included in the 1993 Omnibus Budget Reconciliation Act (OBRA), which passed the House on May 27, 1993.

Omnibus Budget Reconciliation Act of 1993

In 1993, the Omnibus Budget Reconciliation Act imposed a second tier of tax requiring single retirees with incomes above $34,000 and couples with combined incomes above $44,000 to pay tax on up to 85 percent of their benefits. The 85 percent figure was chosen because it was estimated that employee payroll taxes (the portion of contributions from after-tax income) represented at most 15 percent of Social Security benefits. Table 7.1 summarizes the thresholds and calculation of taxable benefits.

Table 7.1
Calculation of Taxable Social Security and
Tier I Railroad Retirement Benefits

Provisional Income	Taxable Social Security and Tier I Railroad Retirement Benefits
Single Taxpayer	
Less than $25,000	None
$25,000 to $34,000	Lesser of (1) 50% of benefits or (2) 50% of provisional income above $25,000 (maximum of $4,500)
Over $34,000	Lesser of (1) 85% of benefits or (2) 85% of provisional income above $34,000 plus the amount in the box above
Married Taxpayer	
Less than $32,000	None
$32,000 to $44,000	Lesser of (1) 50% of benefits or (2) 50% of provisional income above $32,000 (maximum of $6,000)
Over $44,000	Lesser of (1) 85% of benefits or (2) 85% of provisional income above $44,000 plus the amount in the box above

Source: IRS Publication 915. "Social Security and Equivalent Railroad Retirement Benefits."

It is important to remember, the income thresholds used to determine the share of taxable benefits are not indexed for inflation or wage growth. Income taxes on benefits will become an increasingly important source of tax revenues for Social Security and Medicare.

Impact on the Trust Funds

The proceeds from taxing Social Security and Railroad Retirement benefits at the 50% rate are credited to Social Security's two trust funds:

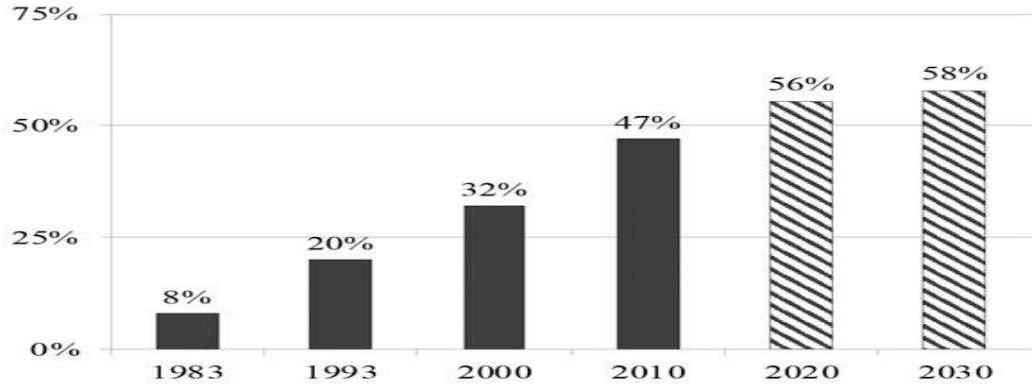
- The Old-Age and Survivors Insurance (OASI) and Disability Insurance (DI) Trust Funds; and
- The Railroad Retirement system, based on the source of the benefits taxed.

Proceeds from taxing benefits at higher rates are credited to the Medicare Hospital Insurance (HI) Trust Fund.

According to the 2025 SSA Trustees Report, in 2024, the OASI and DI Trust Funds were credited with $1,293.3 billion from taxation of benefits or 91.2% of the funds' total income of $1,471.4 billion.

The Congressional Budget Office (CBO) has estimated that about 56 percent of Social Security beneficiaries (35.7 million) are subject to income taxation of their benefits. Under moderate inflation, that percentage is projected to increase to 58 percent in 2030. If inflation rises faster, Social Security benefits will be even higher in nominal dollars. More families will pay for more benefits, further reducing the net benefit (see Figure 7.2). That share will increase to about 50 percent over the next 25 years.

Figure 7.2
Percentage of Social Security Benefit Families Paying Income Tax On Their Benefits, 1983-2030



Note: Striped bars indicate estimates. Source: Purcell (2015).

The Social Security and Medicare trustees project that over the next 20 years, income taxes will grow from 4% of total Social Security tax revenue to 6% and that the share will grow slightly in later decades, approaching 7% by 2090.

Calculating the Tax on Social Security Benefits

The taxable portion of Social Security benefits can be calculated in two steps. The first step in calculating the "surtax" on a beneficiary's Social Security benefit is to find out their "*provisional income.*" Provisional income (also known as *combined income*) is a special term used to define the tax on Social Security benefits. It consists of the following items:

- Modified Adjusted Gross Income (MAGI).
- Plus, one-half of total Social Security benefits (line 5a, IRS Form 1040); plus
- Tax-exempt interest (line 2a, IRS Form 1040).

- = Provisional Income.

Note: Modified Adjusted Gross Income is defined as Adjusted Gross Income (AGI), line 7, IRS Form 1040, and adding back to AGI the following:

- Any income excluded under an employer's adoption assistance program.
- Any deduction is taken of interest on education loans or as a qualified tuition expense; and
- Income earned in a foreign country, a U.S. possession, or Puerto Rico.

The second step is to convert "*provisional income*" into the taxable portion of Social Security benefits. As displayed in Table 7.1 above, there are two threshold amounts in this conversion: $25,000 and $34,000 for singles, heads of households, and qualified widows and widowers with a dependent child. The threshold amounts are $32,000 and $44,000 for couples filing jointly.

The taxable portion of Social Security is the minimum of three amounts:

- 85% of Social Security benefits.
- 50% of benefits plus 85% of provisional income beyond the second threshold amount; or
- 50% of Provisional Income beyond the first threshold plus 35% of provisional income beyond the second threshold amount.

For most clients, the first or third formula will produce the lowest taxable amount threshold. These steps do not tell the whole story. If provisional income is over one of the threshold amounts, then the lesser of 85% (or 50%) of either Social Security benefits (or the amount by which provisional income exceeds the threshold) is added to gross income for tax purposes. To explain this, think of earning $1,000 above the $44,000 threshold; 85% of the $1,000–not the 85% of Social Security–would be added to income. The result would be a tax break for certain moderate-income Social Security beneficiaries. Still, it will have the effect of raising the marginal tax rate for others. Let's see how this works.

> ***Example 1:*** Illustrates different levels of income for Jack and Jill, who are single taxpayers, but they both receive the same amount of Social Security benefits ($15,000). Table 7.3 summarizes the taxation of Social Security benefits.

The calculation of taxable Social Security benefits depends on the level of benefits and the level of non-Social Security income. Holding benefits constant, as non-Social Security income increases, provisional income increases. Therefore, the amount of taxable Social Security benefits increases. Holding non-Social Security income constant, as Social Security benefits increase, taxable Social Security benefits also increase. Those two perspectives are illustrated for a married couple in Examples 2 and 3.

Table 7.3
Example of Calculation of Taxable Social Security Benefits for a Single Social Security Recipient with a $15,000 Benefit

Step 1: Calculate Provisional Income	**Jill**	**Jack**
Other Income (MAGI)	$20,000	$30,000
+ 50% of (assumed) Social Security benefits	$7,500	$7,500
= Provisional Income	$27,500	$37,500
Step 2: Compare Provisional Income to First Tier Threshold		
First Tier Threshold	$25,000	$25,000
The excess over first-tier threshold Lesser of: • Provisional income minus first-tier threshold or • Difference between first and second-tier thresholds	$2,500	$9,000
First-tier taxable benefits equal Lesser of: • 50% of benefits or • 50% of the excess over the first tier	$1,250	$4,500*
Step 3: Compare Provisional Income to Second Tier Threshold		
Second tier threshold	$34,000	$34,000
Calculate excess over the second tier • Provisional income minus the second-tier threshold	$0	$3,500
Second-tier taxable benefits 85% of excess	$0	$2,975
Step 4: Calculate Total Taxable Social Security Benefits		
For John: Provisional income is greater than $34,000, so total taxable benefits equal the lesser of • 85% of Social Security benefits (=$12,750) *or* • First-tier taxable benefits *plus* second-tier taxable benefits ($4,500 + $2,975=$7,475)	$1,250	$7,475

Source**:** Congressional Research Service (CRS). *The maximum amount of first-tier taxable benefits is 50% of the difference between the second and first-tier thresholds ($34,000-$25,000=$9,000x50%=$4,500)

The calculation of taxable Social Security benefits depends on the level of benefits and the level of non-Social Security income. Holding benefits constant, as non-Social Security income increases, provisional income increases. Therefore, the amount of taxable Social Security benefits increases. Holding non-Social Security income constant, as Social Security benefits increase, taxable Social Security benefits also increase. Those two perspectives are illustrated for a married couple in Examples 2 and 3.

> ***Example 2*****:** A married couple filing jointly, Jack and Jill, have a modified adjusted gross income (MAGI) of $45,000. They receive $18,000 per year in Social Security benefits. Table 7.4 summarizes the taxation of Social Security benefits.

Table 7.4
Example of Calculation of Taxable Social Security Benefits for a Married Couple Social Security Recipient with an $18,000 Benefit

Step 1: Calculate Provisional Income	
Other Income (MAGI)	$45,000
+ 50% of (assumed) Social Security benefits	$9,000
= Provisional Income	$54,000
Step 2: Compare Provisional Income to First Tier Threshold	
First Tier Threshold	$32,000
The excess over the first-tier threshold	
Lesser of:	
• Provisional income minus first-tier threshold or	$12,000
• Difference between first and second-tier thresholds ($12,000)	
First-tier taxable benefits equal	
Lesser of:	
• 50% of benefits or	$6,000*
• 50% of the excess over the first tier	
Step 3: Compare Provisional Income to Second Tier Threshold	
Second tier threshold	$44,000
Calculate excess over the second tier.	
• Provisional income minus the second-tier threshold	$10,000
Second-tier taxable benefits	
85% of excess	$8,500
Step 4: Calculate Total Taxable Social Security Benefits	
Provisional income is greater than $44,000, so total taxable benefits equal the lesser of:	
• 85% of Social Security benefits (=$15,300) *or*	$14,500
• First-tier taxable benefits *plus* second-tier taxable benefits ($6,000 + $8,500 = $14,500)	

Source**:** Congressional Research Service (CRS).*The maximum amount of first-tier taxable benefits is 50% of the difference between the second and first-tier thresholds ($44,000-$32,000=$12,000x50%=$6,000)

Example 3: Jack and Jill earn an additional $1,000 in income.

Normally the addition of $1,000 in gross income for a client in the 15% tax bracket would result in $150 in additional tax (1,000 x .15). As shown in Table 7.5, a Social Security beneficiary subject to tax on 85% of the excess over the base amount (Step 3) $1,000 in additional taxable income adds $850 to their gross income. Now the additional tax is 15% of $850, or $127.50 by the $1,000 in income. We see that the effective marginal tax rate–that is, the rate applied to each additional dollar of income is 27.75%.

However, if gross income is high enough that a full 85% of Social Security benefits are added to income, the marginal rate "surtax" goes away. Then, of course, clients pay tax on the full 85% of benefits.

Table 7.5
Example of Calculation of Taxable Social Security Benefits for a Married Couple Social Security Recipient with an $18,000 Benefit

Step 1: Calculate Provisional Income	
Other Income (MAGI)	$46,000
+ 50% of (assumed) Social Security benefits	$9,000
= Provisional Income	$55,000
Step 2: Compare Provisional Income to First Tier Threshold	
First Tier Threshold	$32,000
The excess over the first-tier threshold	
Lesser of:	
• Provisional income minus first-tier threshold or	$12,000
• Difference between first and second-tier thresholds ($12,000)	
First-tier taxable benefits equal	
Lesser of:	
• 50% of benefits or	$6,000*
• 50% of the excess over the first tier	
Step 3: Compare Provisional Income to Second Tier Threshold	
Second tier threshold	$44,000
Calculate excess over the second tier	
• Provisional income minus the second-tier threshold	$11,000
Second-tier taxable benefits	
85% of excess	$9,350
Step 4: Calculate Total Taxable Social Security Benefits	
Provisional income is greater than $44,000, so total taxable benefits equal the lesser of:	
• 85% of Social Security benefits (=$15,300) *or*	$15,300
• First-tier taxable benefits *plus* second-tier taxable benefits ($6,000 + $9,350 = $15,350)	

Source**:** Congressional Research Service (CRS).
*The maximum amount of first-tier taxable benefits is 50% of the difference between the second and first-tier thresholds ($44,000-$32,000=$12,000x50%=$6,000)

As you can see from the above calculations, the marginal tax rate increases when the income is high enough to trigger additional tax on the beneficiary's Social Security benefits but not so high that the full 85% of benefits are taxed. Clients at these income levels have a clear incentive not to earn more income in retirement because it is subject to nearly 2x the tax of an individual with the same income who is not receiving Social Security benefits.

Marginal Tax Rates

When we speak of marginal tax rates (brackets), we refer to the tax imposed on the next dollar earned. This is a particularly useful concept for tax planning. As we showed with the above examples, it allows you to analyze the tax impact of additional income or

additional deductions. The marginal tax bracket is the highest tax rate imposed on one's income.

These marginal tax rates are also called ordinary income tax rates. That's because these tax rates apply to most kinds of income and are distinguished from the more favorable capital gains tax rate imposed on long-term gains and qualified dividends.

Tax rates progressively increase as income increases. However, increasingly higher tax rates apply only to the income in each range, which is called a tax bracket. Also, the tax rates apply only to taxable income. Various adjustments and deductions, including the standard deduction and personal exemptions, lower a person's taxable income. Taxable income is almost always less than one's total income.

Types of Income

It is important to understand the types of income that are not used to calculate Social Security benefits taxation.

For purposes of determining which type of income is taxable, here are some types of taxable income:

- A person's earnings for a taxable year are the sum of payment for services as an employee; plus
- All net earnings from self-employment (minus any net loss from self-employment) for that year.

Wages for Social Security purposes are gross wages, wages before any payroll deductions for income tax, Social Security tax, dues, insurance, or other deductions by the employer. SSA uses gross wages as the basis for Social Security credit and determines whether benefits must be withheld because of earnings.

Other sources of income that would be included in the tax calculation are:

- Pensions.
- Income from investments.
- IRA distributions (does not include Roth IRA distributions);
- Interest.
- 401(k) distributions; or
- Other sources.

The Social Security retirement program insures against loss of earnings from work and not against the failure to have investment income.

Note: Different rules apply if an individual receives Social Security disability benefits or Supplemental Security Income payments. Then they must report all earnings to Social Security. Also, different rules apply if an individual works outside the United States.

If an individual works for wages, income counts when earned, not when paid. If the individual has income earned in one year, but the payment was made in the following year, it should not be counted as earnings for the year received. Some examples are accumulated sick time, or vacation pay and bonuses.

If an individual is self-employed, SSA will count only their net earnings from self-employment. For the self-employed individual, income counts when received, not when earned, unless paid within a year after they become entitled to Social Security and earned before being entitled.

Taxation of Benefits under Special Situations

Below we review several situations that will also provide additional taxation of Social Security benefits.

Lump Sum Distributions

A Social Security beneficiary may receive a lump sum distribution of benefits owed for one or more years prior. In this situation, a beneficiary may choose between two methods for calculating the taxable portion of the lump sum distribution:

- Include all of the benefits for prior years in calculating the taxable benefits for the current year; or
- Recalculate the prior year's taxable benefits using the prior year's income and take the difference between the recalculated taxable benefits and the taxable benefits reported in each prior year.

In either case, the additional taxable benefits are included in taxable income for the current year. Some income sources generally excluded from the provisional income calculation are included in computing the taxable portion of benefits in prior years.

Note: The Bipartisan Budget Act of 2015 has closed the ability to withdraw an application and then refile and request a lump sum benefit of prior benefits, effective April 29, 2016.

Repayments

Sometimes a Social Security beneficiary must repay prior overpayment of benefits. In this case, the taxable Social Security benefits calculation is based on the net benefits–gross benefits less the repayment–even if the repayment is for a benefit received in a previous year. For married taxpayers filing a joint return, net benefits equal the couple's Social Security gross benefits less repayment.

If the repayment results in negative net Social Security benefits, there are two consequences: (1) there are no taxable benefits, and (2) the taxpayer may take a

miscellaneous deduction as part of itemized deductions or a credit for the negative net Social Security benefits.

Coordination of Workers' Compensation

For individuals under FRA, Social Security benefits are reduced by a portion of any Workers' Compensation payments (or payments from some other public disability program) received by the individual. Workers' Compensation is generally not taxable. Any reduction in Social Security benefits due to the receipt of Workers' Compensation is still considered a Social Security benefit, so income taxes are computed based on the full (unreduced) benefit amount.

Treatment of Nonresident Aliens

Citizenship is not required for receipt of Social Security benefits. Non-resident aliens may receive benefits provided they have engaged in covered employment and otherwise meet eligibility requirements. In general, 85% of the Social Security benefits for non-resident aliens are taxable (i.e., none of the thresholds apply) at a 30% rate. However, there are several exceptions to this general rule based on tax treaties, such that nonresident aliens or U.S. citizens living abroad may not have U.S. Social Security benefits subject to U.S. income taxes.

Withholding

In general, withholding for a wage earner is based on the estimated income taxes for a full year of earnings at the periodic (weekly, bi-weekly, monthly, etc.) rate. Taxable Social Security benefits, and the associated taxes, are based on the amount of non-Social Security income earned by a recipient during the tax year. Without knowledge about the amount of other income received by a beneficiary, the Social Security Administration cannot properly determine the amount of taxes that should be withheld from Social Security benefits. Like other taxpayers, Social Security recipients can make quarterly estimated income tax payments. The Uruguay Round Agreements Act (P.L. 103-465) amended the Internal Revenue Code (IRC) to allow individuals to request that monies be withheld from certain federal payments to satisfy their income tax liability; this is commonly referred to as voluntary tax withholding. An amendment to Section 207 of the Social Security Act allowed this voluntary tax withholding from Social Security benefits. Voluntary tax withholding became effective with payments issued in February 1999.

The Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA; P.L. 107-16) permitted voluntary withholding from Social Security benefits at rates of 7%, and equal to the bottom three tax bracket tax rates (currently 10%, 15%, and 25%). The Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 (P.L. 111-312) extended the EGTRRA provisions to the tax year 2012. The American Taxpayer Relief Act of 2012 (ATRA; P.L. 112-240) made the EGTRRA provisions permanent.

Aliens residing outside the United States are subject to different tax withholding rules. Section 871 of the Internal Revenue Code imposes a 30% tax withholding rate on almost all the U.S. income of nonresident aliens unless a lower rate is fixed by treaty. Thus, 30% of 85% (or 25.5%).

IRS Form SSA-1099/1042S Social Security Benefit Statement

An SSA-1099 is the Social Security Administration's tax form mails to a Social Security beneficiary each January. It shows the total amount of benefits received by the beneficiary from Social Security in the previous year. It explains how much Social Security income needs to be reported to IRS on their tax return.

If your client is a non-citizen beneficiary, who lives outside of the United States and received or repaid Social Security benefits last year, the SSA will send them Form SSA-1042S instead. The forms SSA-1099 and SSA-1042S are not available for individuals who receive Supplemental Security Income (SSI).

If your client currently lives in the United States and they need a replacement form SSA-1099 or SSA-1042S, there is a new way to get an instant replacement quickly and easily beginning February 1st by:

- Using their online *mySocial Security* account. Once they are logged in to their account, select the "Replacement Documents" tab.
- Calling SSA at 800-772-1213 (TTY 1-800-3250778) Monday through Friday from 7 a.m. to 7 p.m.; or
- Contacting their local Social Security office.

Reporting Social Security Tax

The number from form SSA-1099 goes on the individual's tax return for the year. Whether filing form 1040 or 1040 SR, the amount will be reported on line 5a and the taxable portion on line 5b.

Note: For the tax year 2021 and later, senior taxpayers (age 65 and older) may choose to use Form 1040 EZ no longer but instead use Form 1040 or Form 1040 SR. For additional information, you can view IRS Publication 554, Tax Guide for Seniors Workbook 2.

Reducing Taxation on Social Security Benefits

Now that you understand the rules on the taxation of Social Security benefits, your next step would be to understand the planning areas involved that could help reduce the taxation on Social Security benefits. Below are several planning recommendations that should be considered:

- Individuals who are going to continue to work in their 60s should delay receiving Social Security benefits.
- Coordinate income and spending needs.
- Reduce taxable income.
- Reduce tax-exempt interest income.
- Tax-efficient investing (tax-deferred annuities and immediate annuities);
- Converting traditional IRAs to Roth IRAs; and
- Carefully plan IRA Required Minimum Distributions.

Use of Annuities

Annuities can reduce the taxes an individual pays on Social Security benefits. This is made possible by repositioning bonds, CDs, and mutual funds into tax-deferred annuities.

As was discussed above, the provisional income formula put into place by Congress in 1983 dictates how much of a beneficiary's Social Security benefits are subject to taxes. It also dictates which income vehicle is included in the provisional income formula and which is excluded.

The net effect of the provisional income formula makes deferred growth from annuities (and life insurance) advantageous concerning taxation of Social Security benefits by keeping the individual in a lower provisional income bracket.

Employing a tax-deferral strategy can allow what's commonly referred to as the "triple compounding" of interest and growth. Triple compounding means that an individual would receive interest on their principal, interest on their interest, PLUS interest on the money they would have otherwise sent off to Uncle Sam. This triple compounding tax-deferral strategy can result in a larger nest egg for the individual and/or their heirs–*even after taxes are ultimately paid*–due to the added component of earning interest on money that would otherwise have been spent on taxes over many years. The idea is similar to using tax deferral in a 401k or an IRA to accumulate funds for retirement rapidly.

Also, immediate annuities would be a tax-efficient way of investing and lowering provisional income and the taxation of Social Security benefits. Why do you ask? The answer is that, with annuitization, the payment is a mixture of both principal and interest. The principal would, of course, be tax-free and not be included in the provisional income formula.

State Income Taxes on Social Security

Although the Railroad Retirement Act prohibits states from taxing railroad retirement benefits, including any federally taxable Tier I benefits (45 U.S.C. § 231m), states may tax Social Security benefits. In general, state personal income taxes follow federal taxes. Many states use as a beginning point for the state income tax calculations either federal adjusted gross income (AGI), federal taxable income, or federal taxes paid. All these

beginning points include the federally taxed portion of Social Security benefits. States with these beginning points for state taxation must then adjust or subtract from income (or taxes) for railroad retirement benefits. A state may also adjust all or part of the federally taxed Social Security benefits. Some states do not begin calculating state income taxes with these federal tax values. Instead, begin with a calculation based on income by source. The state may then include part or all Social Security benefits in the state calculation of income.

Thirty-nine states and D.C. either have no income tax (AK, FL, NV, ND, SD, TN, TX, WA, WY) or do not include Social Security benefits in their calculation for taxable income (AL, AZ, AR, CA, DE, DC, GA, HI, ID, IL, IN, IA, KY, LA, ME, MD, MA, MI, MS, NE, NH, NJ, NY, NC, OH, OK, OR, PA, SC, VA, WI, and WV).

As of May 2024, ten states impose Social Security taxes. They are CO, CT, KS, MN, MT, NM, RI, UT, VT and WV. Keep in mind that not all these 10 states tax Social Security in the same way. Some charge tax only on the income on which federal tax rules impose an income tax, which means that many residents get away without paying anything. Other jurisdictions have specific exemption amounts that help residents avoid tax on at least a portion of their benefits, while others set income limits that differ from federal law.

State Specifics

- *Colorado.* Colorado allows taxpayers to subtract some of their Social Security income (as well as pension income) if they are age 55 or older under the "pension and annuity subtraction."
- *Connecticut.* The amount of Social Security income retirees in Connecticut can deduct depends on their adjusted gross income (AGI). Single Social Security recipients with an AGI of less than $75,000 and married couples with an AGI under $100,000 are exempt from paying state taxes on their benefits. For retirees, whose income exceeds the limits, 75% of their benefits are tax-exempt. Otherwise, retirement income is subject to tax rates ranging from 3% to almost 7%.
- *Kansas.* Kansas provides an exemption for such benefits for any taxpayer whose AGI is $75,000, regardless of filing status. Those with an AGI above this threshold are taxed at the same rate as other income, which ranges from 3.1% to 5.7% in Kansas.
- *Montana.* Similar to federal Social Security income tax rules, single retirees in Montana with incomes under $25,000 and married couples with incomes under $32,000 do not have to pay taxes on their Social Security benefits. The state is considering a bill that would totally repeal the state's tax on Social Security income (it passed a preliminary vote in March, but its future is uncertain). For retirees with incomes above the thresholds, the amount they're taxed ranges from 1% to 6% (though the maximum tax rate will reduce to 5.9% next tax year). The state uses its own calculations to determine the rate — according to the fiscal note attached to House Bill 526, if a taxpayer's total income comes from Social Security payments, up to $50,000 could be exempt.

- *Minnesota,* Minnesota in 2023 Governor Tim Walz signed the 2023 Minnesota tax bill into law on May 24th. The bill includes full Social Security state income tax exemption for those earning less than $100,000 annually (married/joint) or $78,000 (single/head of household) phasing out at $118,000 for single filers and $140,000 for joint filers.
- *New Mexico*. New Mexico passed legislation in early 2022 allowing single residents with AGIs under $100,000 and married couples earning under $150,000 to fully deduct Social Security income. Retirees with incomes above the thresholds are subject to income tax ranging from 1.7% to 5.9%, including on Social Security benefits.
- *Rhode Island*. To be exempted from taxes on Social Security income, Rhode Island residents must be the SSA's full retirement age of 67 (depending on birth year) and have an AGI under $95,800 for individuals and under $119,750 for couples. Otherwise, residents pay between 3.75% and 5.9% in income taxes, including Social Security benefits.
- *Utah.* Utah uses the same calculations as the federal government to determine how much of residents' Social Security income is taxable at the state's 4.65% rate. However, Utah does offer full or partial credit on taxable benefits that was expanded this year with the passage of a tax-cut package. In 2023, single filers with incomes of $45,000 or less are eligible for a full tax credit for Social Security income. Married couples filing jointly and heads of households that report income of $75,000 or less also qualify for the credit. Retirees who earn more can also get a little bit of relief with this credit, which declines by 25 cents for every dollar above the income thresholds.
- *Vermont*. Vermont Lawmakers expanded tax exemptions for Social Security benefits in 2022. Single filers with an AGI of $50,000 or less are fully exempt from paying taxes on their benefits, while those who make between $50,000 to $60,000 are partially exempt. Married couples filing jointly are fully exempt if they have an AGI of $65,000, and those with an AGI of $65,000 to $75,000 are partially exempt. Social Security benefits are fully taxed at the state rate of 3.35% to 8.75% for residents with AGIs above the threshold.
- *West Virginia.* For taxable years beginning on and after January 1, 2024, 35% of the amount of Social Security benefits received and included in federal AGI is allowed as a subtraction from federal AGI when calculating West Virginia taxable income. For taxable years beginning on or after January 1, 2025, 65% of the amount of Social Security benefits received and included in federal AGI may be subtracted. Finally, for taxable years beginning on or after January 1, 2026, 100% of the amount of Social Security benefits received and included in federal AGI may be subtracted.

Further Reading

Government Accountability Offices, Retirement Security: Social Security Programs; GAO-16-75SP, Oct 27, 2015; https://www.gao.gov/products/GAO-16-75SP

Wolters Kluwer, "*How Do States Tax Retirement, Pension, and Social Security Income?";* http://news.cchgroup.com/2019/03/01/states-tax-retirement-pension-and-social-security-income/news/tax-headlines/

Tax Foundation, Does Your State Tax Social Security Benefits? State Tax Treatment of Social Security Benefits, 2021
https://taxfoundation.org/states-that-tax-social-security-benefits-2021/

Nerd Wallet, States that tax Social Security Benefits 2024
Which States Tax Social Security Benefits? - NerdWallet

Chapter 7
Review Questions

1. Social Security benefits were exempt from federal income taxes until what year?

( ) A. 1974
( ) B. 1984
( ) C. 1993
( ) D. 2001

2. "Provisional income" (also called combined income) consists of which of the following?

( ) A. MAGI
( ) B. ½ of Social Security benefits received
( ) C. Tax-exempt interest
( ) D. All of the above

3. The Omnibus Budget Reconciliation Act of 1993 imposed a second tier of tax on up to what percent of Social Security benefits?

( ) A. 25%
( ) B. 50%
( ) C. 85%
( ) D. 100%

4. Marginal tax rates are also called:

( ) A. Ordinary income tax rates
( ) B. Effective tax rates
( ) C. Capital gains tax rates
( ) D. Nominal tax rates

5. Which of the following states do not impose a state income tax on Social Security benefits?

( ) A. Florida
( ) B. Nevada
( ) C. Texas
( ) D. All the above

CHAPTER 8

SOCIAL SECURITY DISABILITY INSURANCE

Overview

The Social Security Disability Insurance (SSDI) program is another component of the federal Social Security (OASDI) system framework. The DI program provides income to non-elderly adults who have worked in the past but whom the Social Security Administration (SSA) now deems unable to work because of a medical condition that is expected to last more than one year or to result in death.

This chapter will review the two components of the federal government's disability insurance benefit programs, the Social Security Disability Insurance (SSDI) program, and the Supplemental Security Income (SSI) program.

Learning Objectives

Upon completion of this chapter, you will be able to:

- Recognize the background of the Social Security Disability Insurance (SSDI) program.
- Outline SSDI eligibility requirements, types of benefits, and amounts.
- Apply the disability determination process.
- Review SSDI data trends.
- Determine Supplemental Social Insurance (SSI) program eligibility and benefit amounts; and
- Distinguish the differences between SSDI and SSI.

SSDI Background

Social Security Disability Insurance (SSDI), authorized by the Social Security Amendments of 1956 (Pub. L No 84-880, § 103, 70 Stat. 807, 815-24), is one component of the framework of support that is the federal Social Security system, which comprises the Old-Age, Survivors, and Disability Insurance programs (OASDI).

The SSDI program provides income to non-elderly adults who have worked in the past but whom the Social Security Administration (SSA) now deems unable to work because of a medical condition that is expected to last more than one year or to result in death.

Only workers younger than the full retirement age–established for the Old-Age component of Social Security–can be eligible for SSDI benefits. Disabled beneficiaries receive monthly payments based on their past earnings for as long as they remain in the program. (Some family members of disabled beneficiaries, including certain spouses and children, are also eligible for benefits.) If SSDI beneficiaries remain disabled and live to their FRA, they transfer to the Social Security retirement program at that age, but their benefits do not change.

On a positive note, SSDI growth has leveled off. Growth in the number of SSDI beneficiaries has slowed to its lowest rate in 25 years. In fact, since 2014, the number of beneficiaries has fallen modestly as demographic and economic pressures on the program have eased.

As of May 2025, 8,223,015 workers were receiving SSDI benefits, representing 11.8 percent of all Social Security beneficiaries. These changes are in large part due to the gradual aging of the population, with the earliest cohorts of the baby-boom generation now moving above normal retirement age, where DI benefits are no longer applicable.

SSDI beneficiaries are mostly older and have severe physical or mental impairments. The typical SSDI beneficiary is in their late 50–75 percent are over age 50. Nearly 35 percent are 60 or older–and suffer from a severe mental musculoskeletal disorder or other debilitating impairment. Physical disorders dominate among beneficiaries aged 50 or older. Mental disorders–including intellectual disability (formerly called mental retardation), mood disorders such as bipolar disease and severe depression, organic mental disorders associated with brain disease or damage, psychotic disorders such as schizophrenia, and other mental impairments–account for half of the beneficiaries under age 50.

SSDI Program Financing Information

The SSDI program is primarily funded through the Social Security payroll tax, a portion of which is credited to a separate Disability Insurance (DI) Trust Fund. The payroll tax is a 15.3% tax on earnings that is split equally between employees and employers.

Payroll tax revenues are used to pay benefits under the Social Security OASDI program and the Medicare Hospital Insurance (HI) program. The Social Security portion of the payroll tax is 12.4% (6.2% each per employee and employer) on earnings up to the taxable maximum ($176,100 in 2025). Of the 12.4%, 10.6% is paid to the OASI Trust Fund, and 1.8% is paid to the DI Trust Fund. In addition to these payroll tax contributions, the DI Trust Fund receives some revenue from the taxation of Social Security benefit payments.

Types of Benefits and Average Benefit Levels

SSDI benefits are based on the worker's past average monthly earnings, indexed to reflect changes in national wage levels (up to five years of the worker's low earnings are excluded). The benefits are adjusted annually for inflation, measured by the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W). Benefits are also provided to dependents (spouses or children), subject to certain maximum family benefit limits. Benefits may be offset (reduced) if the disabled worker simultaneously receives Workers' Compensation or other public disability benefits (discussed below). In addition, individuals who receive SSDI benefits also receive Medicare benefits after a 24-month waiting period.

The SSDI program's rules generally restrict beneficiaries from working and earning substantial amounts while receiving benefits. However, when beneficiaries first return to work, they can earn an unlimited amount for 12 months without losing their benefits. Thereafter, they can earn no more than some specified amount per year. The average earnings of $1,620 per month in 2025 (up from $1,550 in 2024) or $2,700 per month in 2025 (up from $2,590 in 2024) if blind, adjusted for inflation, will cause an individual from receiving any further disability benefits.

SSDI Eligibility Requirements

A disabled worker may be entitled to SSDI if they meet the following statutory requirements:

- The individual is insured, generally requiring either a work history or the work history of a parent or spouse.
- The individual's medical condition meets the definition of disability (defined below);
- The individual has filed a claim for disability benefits.
- The individual has not reached normal retirement age; and
- The individual has completed a five-month waiting period.

As was discussed in Chapter 2, to be insured, the worker must have worked and paid Social Security taxes for a long enough time *and* during a recent period to have earned a specific number of *work credits*. An individual can earn up to four credits each year.

The amount needed for a credit change from year to year. In 2025, for example, a worker can earn one credit for each $1,810 increased from $1,730 in 2024) of wages or self-employment income. When they have earned $7,240 in 2025 (increased from $6,920 in 2024), they will have earned four credits for the year.

The number of work credits needed to qualify for disability benefits depends on the worker's age when they become disabled. Generally, a worker needs 40 credits, 20 of

which are earned in the last 10 years ending with the year they become disabled. However, younger workers may qualify with fewer credits. The rules are as follows:

- *Before age 24*–a worker may qualify with 6 credits earned in the 3-year period ending when their disability starts.
- *Age 24 to 31*–a worker may qualify with credit for working half the time between age 21 and the time they became disabled. For example, if they became disabled at age 27, they would need credit for 3 years of work (12 credits) out of the past 6 years (between ages 21 and 27); and
- *Age 31 or older*–A worker generally needs to have the number of work credits shown in Table 8.1.

Unless the worker is blind, they must have earned at least 20 of the credits in the 10 years immediately before they became disabled.

Table 8.1
Required Number of Work Credits

Born After 1929, Became Disabled At Age	Number of Credits
31 through 42	20
44	22
46	24
48	26
50	28
52	30
54	32
56	34
58	36
60	38
62 and older	40

Source: Social Security Administration http://www.ssa.gov/retire2/credits3.htm#sb=3

Definition of Disability

Even after a working person has enough credits to be generally eligible for SSDI benefits, it is difficult to qualify for disability payments. The reason is the extremely narrow definition of disability.

The exact wording under federal law is quoted below.

> *"The inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to*

result in death or has lasted or can be expected to last for a continuous period of not less than 12 months or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity."

Notice, first, the reference to "*any" substantial gainful activity (SGA)*. "Any" does not consider what the individual is suited to do by training, education, or experience as commercial insurance policies generally do. Neither does the definition consider whether or not employment is available where the individual is located.

In recent years we've seen pockets of the U.S. where job openings simply did not exist. "*Substantial gainful activity*" (SGA) does not necessarily mean full-time work; neither does it mean profitable work. SSDI eligibility simply means the individual is not earning more per month than the ceiling stipulated by law. In 2025, the average earning of $1,620 or more per month ($2,700 or more per month if blind), adjusted for inflation, will cause an individual to cease any further disability benefits.

The second portion of the definition indicates that the reason for the disability must be a physical or mental impairment that can be determined medically. This appears to be straightforward but beware of the common backache condition for which a physician might have difficulty locating the cause. Back problems are quite common and can be debilitating as can other conditions even when no medical explanation is apparent.

Reminder: The condition must be expected to result in the individual's death or is long-term, meaning lasting continuously for 12 months or more.

In addition, an individual is responsible for promptly reporting any improvement in their condition, if they return to work, and certain other events if they are receiving disability benefits.

Once an individual's application for SSDI benefits has been approved, they will receive benefits after a five (5) month waiting period from when the disability began. This means that the Social Security Administration (SSA) will withhold five months of an approved claimant's benefits before starting monthly payments (or, more likely, before calculating back payments owed to the claimant, since it takes so long to get disability approval).

There are several exceptions to this rule. They are:

- *SSI.* SSI claimants who have been approved to receive disability benefits are not subject to the five-month waiting period. SSI claimants will be eligible for their first payment on the first of the month after they apply for disability (but they will likely receive the first few months' payments in SSI back payments since the SSA takes at least a few months to grant disability benefits).
- *Reinstatement***.** If a claimant was approved for SSDI benefits, went back to work, stopped receiving benefits, and then become disabled again, will not have to wait five months to receive benefits, if no more than five years have passed between

their first onset date of disability and the second. This is called *expedited reinstatement*; and

- *Dependent benefits***.** If you are applying for benefits as the child of a disabled worker, your application is not subject to any waiting period. For more information, see our section on SSDI-dependent benefits.

Substantial Gainful Activity (SGA) Defined

The term "substantial gainful activity" (SGA) describes a level of work activity and earnings. Work is "substantial" if it involves doing significant physical or mental activities or a combination of both. For work activity to be substantial, it does not need to be performed on a full-time basis. Work activity performed on a part-time basis may also be SGA. "Gainful" work activity may include:

- Work performed for pay or profit.
- Work of nature is generally performed for pay or profit.
- Work intended for profit, whether a profit is realized.

SSA uses SGA as one of the factors to decide if the individual is eligible for disability benefits. If the individual receives Social Security Disability Insurance (SSDI) benefits, SSA will use SGA to decide if their eligibility for benefits continues after they return to work and complete their Trial Work Period (TWP). If the individual receives SSI benefits based on disability, SSA will apply different standards to determine if their eligibility for benefits should continue. SSA will not use SGA as a factor to determine initial eligibility for SSI benefits if you are blind.

The Five-Month Waiting Period

The five-month waiting period starts on the claimant's *established onset date* (EOD) of disability. (This is the date that the SSA says the claimant became disabled.) Thus, the date of entitlement to Social Security benefits (when the claimant starts to be owed a monthly payment) doesn't start until five months after the EOD. If a worker's disabling condition began before the insurance requirements were met, the waiting period would begin with the first full calendar month after the insured status was gained.

During this waiting period, SSDI benefits cannot be paid. It is important to note that this waiting period begins at the onset of the disabling condition and is not affected by the date a worker applies for SSDI benefits.

Trial Work Period

After the 5-month waiting period, statutes and SSA regulations allow DI beneficiaries to return to work for a limited time without affecting their benefits. Specifically, during the "*trial work period,*" beneficiaries assess their ability to work for as many as 9 months, not necessarily consecutive while receiving benefits, no matter how high their earnings. After completing the trial work period, the extended period of eligibility begins.

According to SSA regulations, the first time a beneficiary works above the SGA level ($1,620 and $2,700 if blind in 2025) in the extended period of eligibility, SSA will decide that the beneficiary no longer meets the requirements for disability due to work and that the disability ceased. However, SSA will continue to pay benefits for the month the disability ceased and the following 2 months, which SSA calls the grace period. Additionally, SSA pays benefits to beneficiaries in any month in which earnings are below SGA during the first 36 months of the extended period of eligibility, the re-entitlement period. Eligibility for benefits will not completely terminate until the beneficiary has substantial earnings after the 36-month entitlement period of the extended period of eligibility.

Disability Benefit Payments for Family Members

If the disabled worker starts receiving disability benefits, certain members of their family also may qualify for benefits on their record. Benefits may be paid to:

- Spouse.
- Divorced spouse.
- Children; and
- Disabled child.

Each family member may be eligible for a monthly benefit of up to 50 percent of the disabled worker's disability rate. However, there is a limit to the amount Social Security can pay their family members. The total depends on the disabled worker's benefit amount and the number of family members who also qualify on their record. The family maximum for a family of a disabled worker is 85 percent of the worker's AIME. However, it cannot be less than the worker's PIA or more than 150 percent.

As of May 2025, SSA was paying SSDI benefits to 8.2 million Americans. This included 7.13 million disabled workers with an average benefit check in the amount of $1,581.97, 999 thousand children of disabled workers with an average benefit check in the amount of $512.13, and 86.6 thousand spouses of disabled workers, receiving a benefit check in the amount of $440.46 (see Table 8.2).

If the sum of the benefits payable on account is greater than the family limit, the benefits to the family members will be reduced proportionately. The disabled worker's individual disability benefit will not be affected.

Note: If the disabled worker has a divorced spouse who qualifies for benefits, it will not affect the benefits they or their family may receive.

Table 8.2
Disabled Beneficiaries: Number and average monthly benefits, by type of benefit and sex, May 2025

Type of Benefit	All		Male		Female	
	Number	Average Monthly Benefit	Number	Average Monthly Benefit	Number	Average Monthly Benefit
Disabled worker	7,137,354	$1,581.97	3,570,258	$1,731.73	3,567,096	$1,432.08
Spouses of a disabled worker	86,644	$440.46	9,221	$405.57	77,321	$444.62
Child of Disabled worker	999,017	$512.13	N/A	N/A	N/A	N/A
Total	8,223,015	$1,439.97	N/A	N/A	N/A	N/A

Source: SSA, www.ssa.gov/cgi-bin/currentpay.cgi

Disabled Widows and Widowers

If the disabled worker is a widow(er) age 50 or older and disabled, they may receive disability benefits even though they do not have enough work credits to qualify. The amount of this benefit depends entirely upon the deceased spouse's average earnings and work record. Because they are based on a spouse's work record, these benefits will end if the disabled surviving spouse remarries.

The surviving disabled widow(er) must also meet the following additional qualifications:

- Must be disabled, as defined by Social Security rules (defined later).
- Their spouse at death must have been fully insured---meaning enough work credits to qualify for disability benefits based on age.
- The disability must have started no later than seven years after the spouse's death.
- If already receiving Social Security benefits as a surviving spouse with children, their disability must have begun no later than seven years after their child or children became adults, causing those benefits to end; and
- If divorced before their former spouse died, they will be eligible for these benefits only if they were married for ten years or more.

Disability Determination Process

Although SSDI (and SSI) are federal programs, both federal and state offices are used to determine eligibility for benefits. Individuals apply for benefits at a local SSA office where they are interviewed to obtain relevant medical and work history and see that the required forms are completed. The case may be denied at that point because the applicant does not have SSDI-insured status or is earning too much money from work (work above the SGA earnings limit) in the case of Social Security disability cases or is above the income and resource limits in the case of SSI disability cases. Otherwise, it is forwarded to the State Disability Determination Service (SDDS) for a medical determination.

The medical determination for both types of disability benefits is made based on evidence gathered in the individual's case file. Ordinarily, there is no personal interview with the applicant from the state personnel who decide the claim.

The SDDS determines whether someone is disabled according to a five-step process called the sequential evaluation process. Current work activity, the severity of impairment, and vocational factors are assessed in that order. An applicant may be denied benefits at any step in the sequential process, even if the applicant may meet a later criterion. For example, a worker that meets the medical listings for disability but earns an amount exceeding the SGA earnings limit would be denied benefits at Step 1. The five steps are as follows:

- Step 1. *Work Test*. Is the individual working and earning over SGA ($1,620 per month or $2,700 per month if blind in 2025)? If yes, the application is denied. If no, the application moves to Step 2.
- Step 2. *Severity Test*. Is the applicant's condition severe enough to limit basic life activities for at least one year? If yes, the application moves to Step 3. If not, the application is denied.
- Step 3. *Medical Listings Test*. Does the condition meet the SSA medical listings, or is the condition equal in severity to one found on the medical listings? If yes, the application is accepted, and benefits are awarded. If not, the application moves to Step 4.
- Step 4. *Previous Work Test*. Can the applicant do the work they had done in the past? If yes, the application is denied. If not, the application moves to Step 5; and
- Step 5. *Any Work Test*. Does the applicant's condition prevent them from performing any other work that exists in the national economy? If yes, the application is accepted, and benefits are awarded. If not, the application is denied.

Reduction in SSDI Benefits

Disability payments from private sources, such as private pensions or insurance benefits, do not affect a worker's Social Security disability benefits. However, Workers' Compensation and other public disability benefits may reduce a disabled worker's Social Security benefits.

Workers' Compensation benefits are paid to a worker because of a job-related injury or illness. They may be paid by federal or state Workers' Compensation agencies, employers, or by insurance companies on behalf of employers.

Other public disability payments that may affect a disabled worker's benefit are those paid by a federal, state, or local government and are for disabling medical conditions that are not job-related.

> ***For Example****:* Civil service disability benefits, state temporary disability benefits, and state or local government retirement benefits that are based on disability.

If a disabled worker receives Workers' Compensation or other public disability benefits and Social Security disability benefits, the total amount of these benefits cannot exceed 80 percent of the disabled worker's average current earnings before becoming disabled.

However, some public benefits do not affect disabled workers' Social Security disability benefits. If a disabled worker receives SS disability benefits and one of the following types of public benefits, the Social Security benefit will not be reduced:

- Veterans Administration benefits.
- State and local government benefits if Social Security taxes were deducted from earnings; or
- Supplemental Security Income (SSI).

To calculate the deduction, a disabled worker's monthly Social Security disability benefits, including benefits payable to their family members, are added together with the disabled worker's compensation or other public disability payment.

If the total amount of these benefits exceeds 80 percent of the disabled worker's average current earnings, the excess amount is deducted from the disabled worker's Social Security benefit.

> ***For Example****:* Tom's average current earnings prior to becoming disabled were $4,000 a month. Tom, his spouse and his two children would be eligible to receive a total of $2,200 a month in SSDI benefits. However, Tom was also receiving $2,000 a month from Workers' Compensation. Because the total amount of benefits Tom would receive ($4,200) is more than 80 percent ($3,200), Tom's family Social Security benefits will be reduced by $1,000.

If a disabled worker's Social Security benefit is reduced, the benefit will be reduced until age 65 is reached, or the month other benefits stop, whichever comes first.

Note: If a disabled worker receives a lump sum Workers' Compensation or other disability payment in addition to or instead of a monthly benefit, the amount of the Social Security benefits they and their family receive may be affected.

SSDI Trust Fund

The Disability Insurance (DI) Trust Fund was created with the passage of the Social Security Act Amendments of 1956. The Board of Trustees currently consists of 6 members, 4 of whom automatically serve by virtue of their positions in the federal government. These 4 are the:

- Secretary of the Treasury (the Managing Trustee).
- Secretary of Labor.
- Secretary of Health and Human Services; and

- Commissioner of Social Security.

The other 2 members are appointed by the President and confirmed by the Senate, as required by the Social Security Amendments of 1983. These 2 members serve 4-year terms.

The 2025 SSA Trustees Report projects the DI Trust Fund to have sufficient reserves to pay full benefits throughout the 75-year projection period ending in 2099. Of the $147 billion in total income in 2024, $187.7 billion (91.2%) was net payroll tax contributions (see Table 8.3).

Table 8.3
Summary of 2024 Operations of the DI Trust Fund

	DI Trust Fund
Total Asset reserves as of December 31, 2023	$147.0
Total Income in 2024	193.8
Net payroll tax contributions	187.7
Interest and investment income	5.4
Taxation of benefits	.7
Total Cost in 2024	157.6
Benefit payments	155.0
RR financial interchange	.1
Administrative expenses	2.5
Net increase in asset reserves in 2024	36.2
Total asset reserves, December 31, 2024	183.2

Source: 2025 Trustees Report, Table II.B1.—Summary of 2024 Operations of the DI Trust Fund
https://www.ssa.gov/OACT/TR/2025/tr2025.pdf

Of the $157.6 billion total cost in 2024, $155 billion was net benefit payments. The total level of net benefit payments increased by 2.0 percent from calendar year 2023 to calendar year 2024, largely due to increases in average monthly benefit amounts and the total amount of retroactive benefits, partially offset by a decrease in the average number of beneficiaries during the year. DI non-interest income, and total income, exceeded total cost in 2024.

During 2024, the reserves in the DI Trust Fund increased by $36.2 billion, from $147.0 billion at the end of 2023 to $183.1 billion at the end of 2024. This $183.2 billion consisted of $183.1 billion in U.S. Government obligations and cash totaling $0.1 billion. The effective annual rate of interest earned by the reserves in the DI Trust Fund during calendar year 2024 was 3.3 percent, higher than the 2.9 percent earned during calendar year 2023.

Supplemental Security Income (SSI)

The Supplemental Security Income (SSI) program was enacted by Title XVI of the Social Security Act of 1972 (P.L. 92-603) and was implemented in 1974. SSI is a needs-based program that provides cash benefits designed to ensure a minimum income to aged, blind, or disabled persons with limited income and assets. According to SSA, 85 percent of SSI recipients received payments because of disability or blindness (7.414 million) as of November 2024.

The SSI program is a means-tested program that does not have work or contribution requirements but restricts benefits to those who meet asset and resource limitations (discussed below). This program is often referred to as a "*program of last resort*" since individuals who apply for benefits are also required to apply for all other benefits to which they may be entitled, such as Social Security retirement or disability benefits, pensions, or unemployment benefits.

Payments under SSI began in January 1974, with 3.2 million persons receiving federally administered payments. By December 1974, this number had risen to nearly 4 million and remained at about that level until the mid-1980s, then rose steadily, reaching nearly 6 million in 1993 and 7 million by the end of 2004. As of May 2025, the number of recipients was 7.409 million. Of this total, 3.9 million were between 18 and 64; 2.5 million were aged 65 or older, and 1.0 thousand were under 18 (see Table 8.4).

Table 8.4
Supplemental Security Income, May 2025

Age	Recipients		Total Payments (millions of dollars)	Average monthly payment (dollars)
All recipients	7,409	100.0%	$5,779	$718.30
Under 18	1,008	13.6%	$963	$847.36
18–64	3,919	52.9%	$3,305	$764.57
65 or older	2,483	33.5%	$1,512	$593.24

Source: Social Security Administration, Supplemental Security Income Record, 100 percent data.
https://www.ssa.gov/policy/docs/quickfacts/stat_snapshot/2025-05.html

Supplemental Security Income Benefits

Maximum Federal Supplemental Security Income (SSI) payment amounts increase with the cost-of-living increases that apply to Social Security benefits. The latest such increase, 2.5 percent, becomes effective January 2025.

The monthly maximum federal SSI payment in 2025, referred to as the federal benefit rate (FBR), is $967 per month (up from $943 in 2024) for an individual living independently and $1,450 for an eligible individual with an eligible spouse (up from $1,415 in 2024), and $484 for an essential person, up from $472 in 2024)

In general, monthly amounts for the next year are determined by increasing the *unrounded annual amounts* for the current year by the COLA effective for January of the next year. The new unrounded amounts are then each divided by 12 and the resulting amounts are rounded down to the next lower multiple of $1 (see Table 8.5).

Table 8.5
Maximum Benefit Rates

	Unrounded Annual amounts for		Monthly Amounts for 2025
Recipient	**2024**	**2025[a]**	
Eligible individual	$11,321.49	$11,604.53	$967
Eligible couple	$16,980.36	$17,404.87	$1,450
Essential person	$5,673.73	$5,815.57	$484

Source: SSA.gov
www.ssa.gov/oact/cola/SSI.html?sub5=24398702-B696-7944-95DC-6EC0D910C25E

All but six states and the Commonwealth of the Northern Mariana Islands supplement the federal SSI benefit with additional payments. Fourteen states and the District of Columbia have state supplements that the SSA either partially or wholly administers, and 30 states self-administer their supplements.

Federal SSI benefit maximums are adjusted annually using the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) to reflect changes in the cost of living. SSA generally sends the monthly SSI payments directly to the recipient. However, SSA assigns representative payees to (1) minors, (2) individuals incapable of physically or mentally managing their own benefits, and (3) individuals declared legally incompetent by a court.

SSI recipients living alone or in households where all members receive SSI benefits are also automatically eligible for the Supplemental Nutrition Assistance Program (SNAP). In most cases, an SSI recipient is eligible for Medicaid.

Disability Defined

In evaluating whether an individual is disabled, the Social Security Administration (SSA) will first look at whether they are currently working. If the individual is working part-time and not earning much money, they won't automatically be denied disability benefits, but doing a substantial amount of work (such as working full-time) guarantees that the applicant will be denied benefits. Here's why.

As part of its definition of disability, the SSA requires that a disability claimant (applicant) be unable to perform substantial gainful activity (SGA).

Substantial Gainful Activity

Substantial gainful activity is work that generally brings in over a certain dollar amount per month. In 2025, that amount is $1,620 for non-blind disabled applicants and $2,700 for blind applicants. If the applicant is making more than that amount per month, the SSA figures that the applicant must not be disabled (in their words, the applicant "can engage in competitive employment in the national economy"). The SSA does not include any income from non-work sources, such as interest, investments, or gifts, in deciding whether an applicant is doing SGA.

Low earnings, however, don't necessarily establish that an individual is unable to work. The SSA will consider the circumstances under which work was performed. The SSA can even consider volunteer activities and criminal activities as SGA if they represent substantial work for which someone would ordinarily be paid (but the agency will not consider hobbies or school attendance to be SGA).

Similarly, high earnings don't necessarily mean the claimant was doing SGA if they were working under special conditions. Applicants can argue that their income would have been lower but for the fact that the applicant:

- Required special assistance from other employees in performing the work.
- Was allowed to work irregular hours or take frequent rest breaks.
- Was provided with special equipment or assigned work especially suited to their impairment.
- Was able to work only because of specially arranged circumstances (for example, other people helped the claimant get to and from work).
- Was permitted to work at a lower standard of productivity or efficiency than other employees; and/or
- Was given the opportunity to work despite his impairment because of a family relationship, past association with the employer, or the employer's concern for the claimant's welfare.

Applicants who work and earn gross monthly income exceeding the SGA threshold are not considered disabled and are ineligible to receive benefits unless they were working under special circumstances. Generally, if the applicant makes over $1,550 when they apply, the claim will be denied almost immediately, without a medical review. Medical records will not even be requested or evaluated because they will be considered ineligible for benefits. How much an applicant earns is one of the first things the SSA checks.

If, however, it is determined that the applicant's work activity does not amount to substantial gainful activity (SGA), they will have passed the first step of the SSA five-step evaluation process, and their medical eligibility will be considered at the next step of the process.

Income Defined

SSI law defines two kinds of income:

- Earned income; and
- Unearned income.

Earned income includes wages, net earnings from self-employment, and earnings from services performed. Most other income not derived from current work (e.g., Social Security benefits, other government and private pensions, Veterans' benefits, Workers' Compensation, and in-kind support and maintenance) is considered "unearned." In-kind support and maintenance include food, clothing, or shelter that is given to an individual. If an applicant (or couple) meets all other SSI eligibility requirements (including the resource test described below), their monthly SSI payment equals the FBR minus their countable income.

> ***For Example*:** If someone pays an applicant's medical bills or offers free medical care or receives money from a social services agency that is a repayment of an amount they previously spent, that value is not considered income to the applicant.

The principal earned income exclusions are:

- The first $65 per month plus one-half of the remainder.
- Impairment-related work expenses of the disabled and work expenses of the blind.
- Income set aside or being used to pursue a plan to achieve self-support by a disabled or blind applicant; and
- Infrequent or irregularly received income ($30 or less a quarter).

The principal unearned income exclusions are:

- The first $20 per month.
- Income set aside or being used to pursue a plan to achieve self-support by a disabled or blind applicant.
- State- or locally funded assistance based on need.
- Rent subsidies under programs administered by the Department of Housing and Urban Development.
- The value of food stamps; and
- Infrequent or irregularly received income ($60 or less a quarter).

Resources

The value of an applicant's resources is used to determine whether they are eligible for SSI in each month. SSI law states that eligibility is restricted to the applicant who has countable resources, determined monthly, that do not exceed $2,000 ($3,000 for a couple). The law does not define what resources are but does stipulate what items are not considered resources.

Regulations state that a resource is cash or other liquid asset or any real or personal property that individuals (or their spouses) own and could convert to cash to be used for their support and maintenance. This definition is consistent with the general philosophy of the SSI program that only items that can be used for an individual's food or shelter should be used in determining their eligibility and benefit amount. Not all resources an individual owns are counted. The value of an item may be excluded or counted only to the extent that its value exceeds specified limits. The principal resource exclusions consist of the following:

- The home and land appertaining to it, regardless of value.
- Life insurance policies whose total face value does not exceed $1,500.
- Burial funds not in excess of $1,500 each for an individual and spouse (plus accrued interest).
- Household goods and personal effects.
- An automobile if used for transportation for the recipient or a member of the recipient's household.
- Property essential to self-support.
- Resources set aside to fulfill a plan to achieve self-support; and
- Amounts deposited into an individual development account, including matching funds and interest earned on such amounts, under the Temporary Assistance for Needy Families program or the Assets for Independence Act.

If an individual disposes of resources at less than fair market value within the 36-month period before applying for SSI or at any time thereafter, the individual may be penalized. The penalty is a loss of benefits for several months (up to a 36-month maximum) obtained by dividing the uncompensated value of disposed-of resources by the federal benefit rate plus the maximum state supplementary payment, if any, applicable to the individual's living arrangement. The penalty does not apply if, among other things, the individual can show that the resources were disposed of exclusively for a purpose other than establishing SSI eligibility.

Comparison of the SSDI and SSI Disability Programs

The SSDI and SSI programs share many concepts and terms. However, as many persons may apply or be eligible for benefits under both programs, there are also many important differences in the rules affecting eligibility (see Table 8.6).

Table 8.6
Comparison of the SSDI and SSI Disability Programs

	SSDI	SSI
Source of Payments	**Disability Trust Fund**	**General Tax Revenues**
Minimum Initial Qualifications Requirements	Must meet SSA disability criteria. Must be "insured" due to contributions made to FICA based on your client's own payroll earnings, or those of their spouse or their parents.	Must meet SSA disability criteria. Must have limited income and resources.
Health Insurance Coverage Provided	Medicare. Consists of hospital insurance (Part A), supplementary medical insurance (Part B), and Medicare Advantage (Part C). Voluntary prescription drug benefits (Part D) are also included. Title XVIII of the Social Security Act authorizes Medicare.	Medicaid. Medicaid is a jointly funded, Federal-State health insurance program for low-income and needy individuals. It covers certain children, some, or all of the aged, blind, and/or disabled in a State who are eligible to receive Federally assisted income maintenance payments. Title XIX of the Social Security Act authorizes Medicaid. The law gives the states options regarding eligibility under Medicaid.
How do we figure the beneficiary's monthly payment amount?	Based on the beneficiary's SSDI monthly payment amount on the worker's lifetime average earnings covered by Social Security. Then reduced if the beneficiary receives Worker's Compensation payments and/or public disability benefits, for example, certain state and civil service disability benefits. Other income or resources do not affect the payment amount. The monthly payment amount is adjusted each year to account for cost-of-living changes.	To figure out your client's payment amount, SSA will start with the Federal Benefit Rate (FBR). In 2025, the FBR is $967 for a qualified individual and $1,450 for a qualified couple. SSA will subtract their countable income from the FBR and then add their state supplement if any. The sections on SSI employment supports explain some of the ways that SSA can exclude income. SSA does not count all the income that your client has. The income amount left after SSA makes all the allowable deductions is "countable income." The FBR is adjusted each year to account for cost-of-living changes.
Is a State Supplemental Payment Provided?	There is no State Supplement payment with the SSDI program.	Many states pay some persons who receive SSI an additional amount that is called a "state supplement." The amounts of these state supplements vary from state to state.

Source: SSA Red Book; https://www.ssa.gov/pubs/EN-64-030.pdf

Further Reading

Social Security Administration, 2020 Red Book; Summary Guide to Employment Supports For People With Disabilities Under The Social Security Disability Insurance (SSDI) And Supplemental Security Income (SSI) Programs
https://www.ssa.gov/pubs/EN-64-030.pdf

Social Security Administration. Annual Report of the Supplemental Security Income Program, 2024
https://www.ssa.gov/OACT/ssir/SSI24/II_Highlights.html

Social Security Monthly Statistical Snapshot, May 2025
https://www.ssa.gov/policy/docs/quickfacts/stat_snapshot/2025-05.html

Social Security Administration, The Facts about Social Security's Disability Program;
https://www.ssa.gov/pubs/EN-05-10570.pdf

Social Security Administration, SSI Federal Payment Amounts For 2025;
https://www.ssa.gov/OACT/COLA/SSI.html

Social Security Administration, *What You Need to Know When You Get Social Security Disability Benefits*;
https://www.ssa.gov/pubs/EN-05-10153.pdf

Chapter 8
Review Questions

1. An SSDI beneficiary can return to work and earn an unlimited amount for how many months without losing their benefits?

( ) A. 12 months
( ) B. 18 months
( ) C. 6 months
( ) D. 3 months

2. What is the substantial gainful activity dollar amount per month for a non-blind person in 2025?

( ) A. $2,700
( ) B. $1,620
( ) C. $967
( ) D. $484

3. A worker must earn at least how many credits in the 10 years immediately before they become disabled to qualify for SSDI?

( ) A. 10
( ) B. 6
( ) C. 20
( ) D. 40

4. Once an individual's application for SSDI benefits has been approved, they will receive benefits after a waiting period of how many months from when the disability began?

( ) A. 5 months
( ) B. 12 months
( ) C. 24 months
( ) D. 10 months

5. What is the maximum federal SSI payment (for a single person) referred to as the federal benefit rate (FBR) in 2025?

( ) A. $1,350
( ) B. $1,820
( ) C. $397
( ) D. $967

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CHAPTER 9

FUTURE OF SOCIAL SECURITY

Overview

Given the importance of Social Security benefits, it's no wonder that older workers and retirees are so concerned about the program's funding problems. If you've read a newspaper, listened to the news on the television, or visited a news website in the past few years, you've heard numerous accounts that Social Security is becoming insolvent. Some say "bankrupt." Of course, many of your clients, too, are beginning to believe this. The result: Many of your clients may be making an emotional decision vs. a financial decision when electing to start their Social Security benefits. The comment that you probably hear most often: "I want to get my money before it goes bankrupt."

In fact, a recent poll shows that Social Security's funding situation might influence the claiming decision for at least some future retirees. While fewer than one-third of this group plan to start Social Security before their full retirement age (FRA), of those who will, 17 percent cited their belief that Social Security won't be around at their full retirement age. That's a shame because, as we have shown in the previous chapters, delaying Social Security benefits is one of the best ways to increase the amount of benefits paid over a retiree's lifetime.

This chapter will examine the financial operations and the short and long-range results of the 2025 SSA Trustees Annual Report, the 85th Report from the Board of Trustees of the Federal Old-Age and Survivors Insurance, and Federal Disability Insurance Trust Funds. It will also review some of the proposals to fix the problems with OASDI.

Learning Objectives

Upon completion of this chapter, you will be able to:

- Explain the history and the operations of the Social Security Trust Funds.
- Determine how the changing demographics and social insecurity have affected the OASDI program.
- Describe the Social Security Trust Funds, its short-range and long-range goals; and
- Outline the proposed changes to the Social Security Program and how they may affect benefits now and in the future.

Once you have this knowledge, you will be better positioned to help your clients decide not based on their emotions but their financial objectives. Let's begin with a review of the background of the Social Security Trust Funds.

Social Security Trust Funds

The Federal Old-Age and Survivors Insurance (OASI) Trust Fund was established on January 1, 1940, as a separate account in the United States Treasury. The Federal Disability Insurance (DI) Trust Fund, another separate account in the United States Treasury, was established on August 1, 1956. These funds conduct the financial operations of the OASI and DI programs. The Board of Trustees is responsible for overseeing the financial operations of these funds. The following paragraphs describe the various components of trust fund income and cost.

The primary income of these two funds comes from appropriations under permanent authority based on payroll tax contributions. Federal law requires that all employees who work in OASDI-covered employment, and their employers, make payroll tax contributions on their wages up to a specified annual maximum amount (the contribution and benefit base). Employees and their employers must also make payroll tax contributions on monthly cash tips if such tips are at least $20. Self-employed persons must make payroll tax contributions on their covered net earnings from self-employment subject to the annual contribution and benefit base. The Federal Government pays amounts equivalent to the combined employer and employee contributions that would be paid on deemed wage credits attributable to military service performed between 1957 and 2001 if such wage credits were covered wages. Treasury initially deposits payroll tax contributions to the trust funds each day on an estimated basis. Subsequently, Treasury adjusts based on the certified amount of wages and self-employment earnings in the records of the Social Security Administration.

Income also includes various reimbursements from the General Fund of the Treasury, such as:

- The cost of noncontributory wage credits for military service before 1957, and periodic adjustments to previous determinations of this cost.
- The cost in 1971 through 1982 of deemed wage credits for military service performed after 1956.
- The cost of benefits to certain uninsured persons who attained age 72 before 1968.
- The cost of payroll tax credits provided to employees in 1984 and self-employed persons in 1984 through 1989 by Public Law 98-21.
- The cost in 2009 through 2017 of excluding certain self-employment earnings from SECA taxes under Public Law 110-246; and
- Payroll tax revenue is forgone under the provisions of Public Laws 111-147, 111-312, 112-78, and 112-96.

Beginning in 1984, Federal law subjected up to 50 percent of an individual's or couple's OASDI benefits to Federal income taxation under certain circumstances. Effective for

taxable years beginning after 1993, the law increased the maximum percentage from 50 percent to 85 percent. Treasury credits the proceeds from this taxation of up to 50 percent of benefits to the OASI and DI Trust Funds in advance, on an estimated basis, at the beginning of each calendar quarter, with no reimbursement to the General Fund for interest costs attributable to the advance transfers. The Treasury makes subsequent adjustments based on the actual amounts shown on annual income tax records. Each of the OASI and DI Trust Funds receives the income taxes paid on the benefits from that trust fund.

Another source of income for the trust funds is interest received on investments held by the trust funds. Daily, Treasury invests trust fund income in interest-bearing obligations of the U.S. Government. These investments include the special public-debt obligations described in the next paragraph. The Social Security Act also authorizes trust funds to hold obligations guaranteed as to both principal and interest by the United States. The act, therefore, permits the trust funds to hold certain Federally sponsored agency obligations and marketable obligations. The trust funds may acquire any of these obligations on the original issue at the issue price or by the purchase of outstanding obligations at their market price. The Social Security Act authorizes the issuance of special public-debt obligations for purchase exclusively by trust funds. The act provides that the interest rate for special obligations newly issued in any month is the average market yield, as of the last business day of the prior month, on all the outstanding marketable U.S. obligations that are due or callable more than 4 years in the future. This rate is rounded to the nearest one-eighth of one percent. Beginning in January 1999, in calculating the average market yield rate for this purpose, the Treasury incorporates the yield to the call date when a callable bond's market price is above par.

Although the Social Security Act does not authorize the purchase or sale of special issue securities in the open market, Treasury redeems special issue securities prior to maturity at par value when needed to meet current operating expenses. As a result, changes in market yield rates after issuance of special issue securities do not cause fluctuations in the value of these securities. As is true for marketable Treasury securities held by the public, the full faith and credit of the U.S. Government backs all the investments held by the trust funds.

The annual cost for the OASI and DI Trust Funds primarily consists of the:

- OASDI benefit payments, net of any reimbursements from the General Fund of the Treasury for unnegotiated benefit checks; and
- Expenses incurred by the Social Security Administration and the Department of the Treasury in administering the OASDI program and the provisions of the Internal Revenue Code relating to the collection of contributions.

Such administrative expenses include, among other items, the cost of

- Payroll.
- Construction, rental, lease, or purchase of office buildings and related facilities for the Social Security Administration; and

- Information technology systems. The Social Security Act prohibits payments from the OASI and DI Trust Funds for any purpose not related to the payment of benefits or administrative costs for the OASDI program.

Annual cost also includes:

- The costs of vocational rehabilitation services furnished to disabled persons receiving cash benefits because of their disabilities, where such services contributed to their successful rehabilitation; and
- Net costs of the provisions of the Railroad Retirement Act provide for a system of coordination and financial interchange between the Railroad Retirement program and the Social Security program.

Under the financial interchange provisions, the Railroad Retirement program's Social Security Equivalent Benefit Account and the trust funds interchange amounts on an annual basis so that each trust fund is in the same position it would have been had railroad employment always been covered under Social Security.

The statements of the operations of the trust funds in this report do not include the net worth of facilities and other fixed capital assets because the value of fixed capital assets is not available in the form of a financial asset redeemable for the payment of benefits or administrative costs. As a result of this unavailability, the actuarial status of the trust funds does not take these assets into account.

Trustees of the Trust Funds

There are six Trustees, four of whom serve by virtue of their positions in the federal government:

- Secretary of the Treasury, Janet Yellen.
- Acting Secretary of Labor, Julie A. Su.
- Secretary of Health and Human Services, Xavier Becerra, and
- Commissioner of Social Security, Martin O'Malley.

The other two Trustees are public representatives appointed by the President, subject to confirmation by the Senate. Currently, both seats are vacant.

2025 Trustees Trust Fund Annual Report

The Social Security Act requires that the Board of Trustees, among other things, report annually to Congress on the actuarial status and financial operations of the OASI and DI Trust Funds. The 2025 report is the 85th such report.

Trust Fund Major Findings

Since last year's report, one law was enacted that is projected to have a substantial effect on Social Security's financial status.

- Social Security Fairness Act of 2023: Enacted on January 5, 2025, this law repeals the Windfall Elimination Provision and Government Pension Offset, which reduced or eliminated the Social Security benefits of individuals receiving a pension based on work that was not covered by Social Security. Therefore, implementation of this law increases Social Security benefits for people who worked in jobs that were not covered by Social Security.

In addition, the Trustees have reassessed their expectations and have made changes to the intermediate assumptions in two primary areas.

- Total fertility rate (TFR): The ultimate TFR is 1.9 children per woman, unchanged from last year's report. For last year's report, the ultimate rate was reached in 2040. In this year's report, the ultimate rate is reached ten years later, in 2050.
- Ratio of total labor compensation to Gross Domestic Product (GDP): The ratio of total labor compensation to GDP (that is, the labor share of output) is assumed to increase gradually to 61.2 percent in 2034 and to remain nearly constant thereafter. In last year's report, this ratio was assumed to reach 62.8 percent in 2033 and to stay at about that level.

At the end of 2024, the OASDI program was providing benefit payments1 to about 68 million people:

- 54 million retired workers and dependents of retired workers,
- 6 million survivors of deceased workers, and
- 8 million disabled workers and dependents of disabled workers.

During the year, an estimated 184 million people had earnings covered by Social Security and paid payroll taxes on those earnings.

The total program cost in 2024 was $1,485 billion. Total income was $1,418 billion, which consisted of $1,349 billion in non-interest income and $69 billion in interest earnings. Asset reserves held in special issue U.S. Treasury securities declined from $2,788 billion at the beginning of the year to $2,721 billion at the end of the year (see Table 9.1)

Table 9.1
Summary of 2024 Trust Fund Financial Operations
(In Billions)

	OASI	DI	OASDI
Asset reserves at end of 2023	$2,641.5	$147.0	$2,788.5
Total Income in 2024	1,224.0	193.8	1,4127.8
Net payroll tax contributions	1,105.6	177.7	1,293.3
Interest	63.7	5.4	69.1
Taxation of benefits	54.4	.7	55.1
Total cost in 2024	1327.2	157.6	1,484.8
Benefit payments	1,316.4	155.0	1,471.4
Administrative expenses	4.9	2.5	7.4
Railroad Retirement financial interchange	5.9	.1	5.9
Net increase in asset reserves in 2024	-103.2	36.2	-67.0
Assets reserves at the end of 2024	2,538.3	183.2	2,721.5

Source: The 2025 Social Security Trustees Report:
https://www.ssa.gov/OACT/TR/2025/tr2025.pdf

Short-Range Results (2025-34)

Under the Trustees' intermediate assumptions, Social Security's total cost is projected to be higher than its total income in 2025 and all later years. Total cost began to be higher than total income in 2021. Social Security's cost has exceeded its non-interest income since 2010.

To illustrate the Social Security program's actuarial status as a whole, the OASI and DI Trust Funds' operations are often shown on a combined basis as OASDI. However, the two funds are separate entities by law, and therefore the combined fund operations and reserves are hypothetical. The combined reserves are projected to decrease from $2,721 billion at the beginning of 2025 to $214 billion at the beginning of 2034, and are then expected to become depleted during 2034, the last year of the short-range period.

The OASDI reserves along with projected program income are sufficient to cover projected program cost over the next 9 years under the intermediate assumptions. The ratio of reserves to annual cost is projected to decline from 169 percent at the beginning of 2025, falling below 100 percent to 95 percent at the beginning of 2029. It is projected to remain below 100 percent until reserves become depleted during 2034.

Because this ratio falls below 100 percent by the end of the 10th projection year, and remains below 100 percent, the hypothetical OASDI fund fails the Trustees' test of short-range financial adequacy. For last year's report, the combined reserves were projected to be 188 percent of annual cost at the beginning of 2024, falling below 100 percent to 84 percent at the beginning of 2030.

Considered separately, the OASI Trust Fund fails the test of short-range financial adequacy, but the DI Trust Fund satisfies the test. The OASI reserves are projected to become depleted during 2033 under the intermediate assumptions. The DI reserves along with projected program income are sufficient to cover projected program cost over the next 10 years.

Long-Range Results (2025–2099)

Under the Trustees' intermediate assumptions, OASDI cost exceeds total income in every year of the long-range period, which runs from 2025 through 2099. The hypothetical combined trust fund reserves decline until reserves become depleted in 2034, one year earlier than projected in last year's report.

Considered separately, the OASI reserves become depleted in 2033, which is the same year projected in last year's report. As in last year's report, the DI reserves do not become depleted within the 75-year long-range projection period.

The DI program continued to have low levels of disability applications and benefit awards through 2024. Disability applications have declined substantially since 2010, and the total number of disabled-worker beneficiaries in current payment status has been falling since 2014.

Over the 75-year long-range period, the projected OASDI annual cost rate increases from 15.15 percent of taxable payroll for 2025 to 18.96 percent for 2081 and then decreases generally to 18.34 percent for 2099. The projected cost rate for 2099 is 4.84 percent of taxable payroll more than the projected income rate for 2099. For last year's report, projected OASDI cost for 2099 was 18.16 percent, or 4.67 percent of payroll more than the annual income rate.

When expressed as a share of GDP, OASDI cost generally rises from 5.3 percent of GDP for 2025 to a peak of about 6.4 percent for 2079. It then declines to 6.1 percent by 2099.

OASDI cost has generally increased much more rapidly than taxable payroll since 2008 and is projected to continue to do so through about 2040. In this period, the baby-boom generation is aging and increasing the number of beneficiaries much faster than the increase in the number of covered workers, as subsequent lower-birth-rate generations replace the baby-boom generation at working ages. Between about 2040 and 2080, the OASDI cost rate continues to grow, but at a slower pace. After 2080, the OASDI cost rate declines and then stabilizes.

These patterns in the cost rate are largely driven by the effect of birth rates on the adult population's age distribution. Birth rates are assumed to increase from recent very low levels to an ultimate level of 1.9 children per woman for 2050 and thereafter. In last year's report, the same ultimate total fertility rate of 1.9 children per woman was assumed for 2040 and later.

The OASDI actuarial deficit is 3.82 percent of taxable payroll for the 75-year projection period 2025-99, which is larger than the value of 3.50 percent for 2024-98 in last year's report. The open-group unfunded obligation for OASDI is 3.64 percent of taxable payroll for 2025-99, which is larger than the value of 3.32 percent of payroll for 2024-98 in last year's report.

Expressed in present-value dollars discounted to January 1, 2025, the open group unfunded obligation for OASDI is $25.1 trillion over the 75-year projection period 2025-99. This is $2.5 trillion more than the measured level in last year's report of $22.6 trillion over 2024-98, discounted to January 1, 2024.

The OASDI actuarial deficit and unfunded obligation both round to 1.3 percent of GDP over the 75-year projection period 2025-99, compared to 1.2 percent for both the actuarial deficit and the unfunded obligation over 2024-98 in last year's report.

If the assumptions, methods, starting values, and the law had all remained unchanged, the actuarial deficit would have increased to 3.56 percent of taxable payroll, and the unfunded obligation would have risen to 3.38 percent of taxable payroll and $23.5 trillion in present value. This is due to the change in the valuation date and the extension of the valuation period through an additional year, 2099.

The actuarial deficit increased significantly in this year's report primarily due to:

- The implementation of the Social Security Fairness Act,
- The extension in the assumed year the ultimate total fertility rate is reached, and
- The reduction in the ultimate assumption for the ratio of total labor compensation to GDP. These changes are described in detail in section IV.B.6 of this report.

To illustrate the magnitude of the 75-year actuarial deficit, consider that for the combined OASI and DI Trust Funds to remain fully solvent throughout the 75-year projection period ending in 2099:

- Revenue would have to increase by an amount equivalent to an immediate and permanent payroll tax rate increase of 3.65 percentage points1 to 16.05 percent beginning in January 2025;
- Scheduled benefits would have to either be reduced by an amount equivalent to an immediate and permanent reduction of 22.4 percent applied to all current and future beneficiaries effective in January 2025, or by 26.8 percent if the reductions were applied only to those who become initially eligible for benefits in 2025 or later; or
- Some combination of these approaches would have to be adopted.

If substantial actions are deferred for several years, the changes necessary to maintain solvency for the combined OASI and DI Trust Funds would be concentrated on fewer years and fewer generations. Significantly larger changes would be necessary if action is deferred until the combined trust fund reserves become depleted in 2034. For example, maintaining 75-year solvency through 2099 with changes that begin in 2034 would require:

- An increase in revenue by an amount equivalent to a permanent 4.27 percentage point payroll tax rate increase to 16.67 percent starting in 2034,
- A reduction in scheduled benefits by an amount equivalent to a permanent 25.8 percent reduction in all benefits starting in 2034, or
- Some combination of these approaches.

Conclusion

Under the intermediate assumptions, the projected hypothetical combined OASI and DI Trust Fund reserves become depleted and unable to pay scheduled benefits in full on a timely basis in 2034. At the time of reserve depletion, continuing income to the combined trust funds would be sufficient to pay 81 percent of scheduled benefits. The OASI Trust Fund reserves are projected to become depleted in 2033, at which time OASI income would be sufficient to pay 77 percent of OASI scheduled benefits. DI Trust Fund reserves are not projected to become depleted during the 75-year period ending in 2099.

Next, let's review some of the suggested options discussed to reform Social Security.

Reforming Social Security Sooner Rather Than Later

As was discussed above, Social Security's combined trust fund reserves are projected to become depleted around 2034, at which time its income would be able to pay only 80% of the benefits scheduled for its 80 million beneficiaries. It is important that Congress immediately focus on this issue because delay makes the solution more difficult, as it gradually limits the viable options to those relying on increasing taxes. According to a recent Issue Brief by the American Academy of Actuaries, released October 2023, it claims "if Congress has not acted by 2034, we will be faced with:

- An automatic 20% cut in benefits to people already receiving benefits,
- The need to immediately increase Social Security taxes by 25%, or
- Some combination of cuts in benefits and increases in taxes.

When Congress amended Social Security in the past, benefit reductions were only applied to individuals not yet eligible for benefits, so current recipients did not have their benefits cut. In addition, Congress has always phased in large benefit reductions, as a large reduction to one cohort, while not affecting the prior cohort, could be seen as unfair. If Congress wants to continue these two traditions, and avoid a large tax increase in 2034, reform is needed as soon as possible so that the phased-in changes are enough to pay all

benefits in 2034. Congress will have more reform options if they act sooner. Earlier action allows for tax increases and benefit reductions to be phased in gradually and makes it less likely that a 25% payroll tax increase is needed in 2034. Earlier action is also important to individuals, as it provides them with more time to plan and adjust to the changes, enables them to make better decisions now, and provides greater confidence that they will receive their benefits. In addition, earlier action enables Congress to also impact people over the next 10 years, so that benefit reductions can be smaller, as discussed in the 2023 Trustees Report. The last time the trust funds were close to depletion was in 1983. The cash shortfall that year was 1.0% of taxable payroll. In contrast, the expected cash shortfall in 2034 will be three times as large (3.12% of taxable earnings, per Table VI. G2), so paying all benefits that year will require much larger tax increases and/or benefit reductions than in 1983. If Congress cannot agree on Social Security reform until 2034, enacting benefit reductions for only those who become eligible for benefits in 2034 or later will not help, so delay could force them to increase Social Security taxes by 25% in 2034 (unless Congress is willing to break its tradition of not cutting benefits already being paid or is willing to use general revenue). That may be difficult, as Congress may also need to enact tax increases to keep Medicare's Hospital Insurance Trust Fund from being depleted around 2031 (see Chapter 11). The following discusses reforms that can help eliminate Social Security's cash shortfall by 2034.

Options to Reform Social Security

To keep providing Social Security benefits, it is generally agreed that changes need to happen with how the system works. What is not agreed on, though, is what the changes should be. Below are proposed options (fixes) suggested over the past several years, their pros and cons. Five options would reduce benefits, and two options would increase payroll taxes. You can go to the Congressional Budget Office website at: https://www.cbo.gov/publication/54868 and use the interactive tool to explore these policy options that could be used to improve the Social Security program's finances and delay the trust fund exhaustion.

Raise the Retirement Age

As was discussed in Chapter 3, the age at which workers become eligible for full retirement benefits from Social Security–the full retirement age (FRA), also called the normal retirement age–depends on their year of birth. For workers born in 1937 or earlier, the FRA is 65. It increases in two-month increments for each successive birth year until it reaches 66 for workers born in 1943. For workers born between 1944 and 1954, the FRA holds at 66, but it increases again in two-month increments and reaches age 67 for workers born in 1960 or later. The earliest age at which workers may start to receive *reduced* retirement benefits is 62 for all workers; however, benefit reductions at that age will be larger for workers whose FRA is higher. For example, workers born in 1954 (whose FRA is 66) will receive a permanent 25 percent benefit reduction in their monthly benefit amount if they claim benefits at age 62 rather than at their FRA. In contrast, workers born in 1960 (whose FRA is 67) will receive a 30 percent reduction if they claim benefits at 62.

Under this option, the FRA would continue to increase from age 67 by two months per birth year until it reached age 70. (If the "sooner" start date is selected, that increase would begin with workers turning 62 in 2023; if the "later" start date is selected, the increase would begin with workers turning 62 in 2026.) Under current law, workers could still choose to begin receiving reduced benefits at age 62, but the reduction in their initial monthly benefit would be larger, reaching 45 percent when the FRA is 70.

Pro: Many advocates of this option argue that raising the retirement age makes sense because life spans are rising. The advantage of raising the retirement age, compared to other options for balancing Social Security, would encourage people to work longer. By delaying retirement, workers avoid early retirement reductions to Social Security and pension credits, and other savings and reduce the number of retirement years they must fund. By working to age 67 instead of retiring at age 62, a typical worker could gain about $10,000 in annual income at age 75, significantly reducing the likelihood of falling into poverty at older ages. Further, working longer would increase the total production of goods and services in the economy, enhancing living standards and raising government revenues that fund services, including Social Security. According to The Retirement Project, if raising the retirement age led all workers to delay retirement by even one year, the additional payroll and income tax revenue generated would be as much as 28 percent of the annual Social Security deficit in 2045.

Con: An increase in the FRA would reduce lifetime benefits for every affected Social Security recipient, regardless of the age at which a person claims benefits. Workers could maintain the same monthly benefit by claiming benefits at a later age, but then they would receive benefits for fewer years. Some argue that increasing the retirement age would be unfair to lower-income individuals. In addition, some insist that it's simply unfair to ask Americans–especially those who perform manual labor–to work more years before becoming eligible for benefits. You can read the white paper: *Would Raising the Social Security Retirement Age Harm Low-Income Groups?* at: https://www.urban.org/sites/default/files/publication/46161/311413-Would-Raising-the-Social-Security-Retirement-Age-Harm-Low-Income-Groups-.PDF.

Increase the Number of Years to Calculate Initial Benefits

As was discussed in Chapter 3, Social Security retirement benefits are based on a worker's average earnings history. Average earnings are computed from a worker's highest 35 years of annual indexed earnings subject to Social Security payroll taxes. If a worker has fewer than 35 years of earnings, each year needed to reach 35 is assigned zero earnings. One option to help close the Social Security funding gap would increase the number of years of earnings used to calculate Social Security retirement benefits from 35 to 38 or even 40. Because that method would typically include more years of lower earnings, the average earnings would decrease, and benefits would be lower. Increasing the number of computation years to 38 is estimated to fill 13 percent of the solvency gap.

Pro: Using only 35 years of an individual's earnings during their work history skews the picture of an individual's full employment history and provides inaccurate Social

Security benefits. Under the current method, an individual who goes to work full time at age 21 has worked and paid Social Security taxes for 45 years by the time they reach Social Security's current full retirement age (age 66). Going to work at age 18 adds three years to a 48-year work history. Meanwhile, people could wait until age 30 before going to work and still receive full credit toward their eventual retirement benefits, allowing them to pay fewer years of Social Security payroll taxes than someone who works longer but get the same benefits. Increasing the number of years used to calculate an individual's Social Security benefit would provide an added incentive for them to go into the workforce sooner and to keep working. It would also enable the Social Security Administration to use a more complete picture of an individual's working life to calculate benefits. In fairness, for many workers, a change to counting 38 years of earnings would include some lower earning years that today's 35-year work history ignores. That would slightly reduce benefit levels. Moving to a required 40-year work history would reduce them slightly more. On the other hand, people who continue to work beyond their full retirement age would still receive higher benefits than those who retire earlier and could thereby make up for that difference in most cases.

Con: This proposal is a bad idea because it would reduce benefits the most for people who need them the most: women and lower-income, less-educated, and minority retirees. It would reduce benefits not only for retired workers but also for their dependents and survivors. The cuts would occur because many retirees do not have a full 35 years of earnings, much less 38 or 40 years. The largest reductions would affect people with gaps in their covered work histories, typically women. This change would have little or no impact on the benefits of people who have worked steadily for 38 or 40 years–but far fewer people than might be expected have such work records. Most workers have gaps in their work histories because of periods of unemployment, incomplete work records, or temporary illness or disability. The Social Security Administration estimates that about 75 percent of those receiving retired-worker benefits would experience a benefit cut if the computation period increased to 40 years. Social Security benefits are modest and already being cut as a result of changes enacted in 1983 (raising the full retirement age). Cutting them further is unnecessary, as many Americans report that they would rather pay more for Social Security than see future benefits cut further.

Make Social Security's Benefit Structure More Progressive

The amount of the Social Security benefit paid to a disabled worker or to a retired worker who claims benefits at the full retirement age is called the primary insurance amount (PIA). The Social Security Administration calculates that amount using a formula applied to a worker's average indexed monthly earnings (AIME), a measure of average taxable earnings over that worker's lifetime. The benefit formula is progressive, meaning that the benefit is larger as a share of lifetime earnings for someone with a lower AIME than it is for a person with a higher AIME. To compute a worker's PIA, the Social Security Administration separates that worker's AIME into three brackets by using two bend points (or dollar threshold amounts). As was discussed in Chapter 3, in the calendar year 2024, the first bend point is $1,174, and the second bend point is $7.078. Average indexed earnings in each of the three brackets are multiplied by three corresponding factors to determine the PIA: 90 percent for the earnings in the lowest bracket, 32 percent

for earnings in the middle bracket, and 15 percent for earnings in the highest bracket. Bend points rise each year with average wages, whereas the factors remain constant.

> ***For Example:*** A worker with an AIME of $9,975 would have a PIA of $3,380.50. The 90 percent factor would apply to the first $1,1174 = $1,056.60, the 32 percent factor would apply to the next $5,904 ($7,078 minus $1,174) = $1,889.28, and the 15 percent factor would apply to the remaining $2,897 ($9,975 minus $7,078) = $2,897 x .15 = $434.55. Add: $1,056.60 + $1,889.28 + $434.55 = $3,380.43 (rounded up $3,380.50).

These two options would make the Social Security benefit structure more progressive by cutting benefits for people with higher average earnings while preserving or expanding benefits for people with lower earnings. The first option, 90/32/5 PIA factors, would affect only beneficiaries with an AIME above the second bend point. That approach would reduce the 15 percent PIA factor by 1 percentage point per year until it reached 5 percent.

The more progressive second option, 100/25/5 PIA factors, would reduce benefits for a larger fraction of beneficiaries with higher lifetime earnings while increasing those with lower lifetime earnings. It would lower both the 15 percent and 32 percent factors and would increase the 90 percent factor. The factors would change gradually over 10 years until they reached 5 percent, 25 percent, and 100 percent, respectively. (The 15 percent and 90 percent factors would change by 1 percentage point per year, while the 32 percent factor would change by 0.7 percentage points per year.)

The first alternative would reduce total federal outlays for Social Security over the 10-year period by about $7 billion, the Congressional Budget Office (CBO) estimates. That estimate is based on the CBO projections of the share of newly eligible beneficiaries affected by that approach and the average reduction in their benefits. By 2028, based on data provided by the Social Security Administration, CBO estimates that about 2.5 million people, or 13 percent of all newly eligible beneficiaries, would be affected. For people who become eligible in 2028, the average decline in monthly benefits for those affected would amount to 4 percent, or about $150, relative to amounts under current law.

The second alternative would achieve total federal savings of $36 billion over the 10-year period. CBO estimates that about 45 percent of new beneficiaries would receive benefits that are higher than under current law. In comparison, 55 percent of new beneficiaries would receive benefits that are lower. People who become eligible in 2028 and would get increased benefits would, on average, receive 6 percent, or about $70 per month, more than under current law; the average decrease for people whose benefits would be reduced would amount to about 8 percent or $220 per month.

Annual savings from both alternatives would grow over time as the new benefit structure applied to more beneficiaries. In 2048, the first and second alternatives would reduce Social Security outlays from what would occur under the current law by 2 percent and 6 percent, respectively. When measured as a percentage of total economic output, the reduction in Social Security outlays under the two alternatives would be 0.2 percentage

points and 0.4 percentage points, as the outlays fell from 6.3 percent of gross domestic product to 6.1 percent and 5.9 percent, respectively.

To achieve greater budgetary savings, larger reductions in the 15 percent and the 32 percent PIA factors could be implemented. (Conversely, smaller reductions would result in fewer savings.) In addition, to target benefit reductions more narrowly, one or more additional bend points could be added to the formula.

The overall savings from the alternatives in this option could be higher or lower than shown because the projected distribution of earnings and the resulting benefits are uncertain. For example, if earnings were more equally distributed than CBO has projected, resulting in more people with an AIME above the second bend point, the savings from both approaches would be slightly higher than shown because the reduction in benefits would apply to more people.

Pro: An argument in favor of this option is that it would better target Social Security benefits toward people who need more protection or expanding benefits for people with low average earnings while reducing payments to people with higher average earnings. This option would help make the Social Security system more progressive when growing disparities in life expectancy by income level are making the system less progressive. (Beneficiaries with higher income typically live longer and experience larger improvements in their life expectancy than lower-income beneficiaries. As a result, higher-income groups receive benefits for more years, on average, than lower-income beneficiaries.) The second approach in this option would increase progressivity more than the first approach by boosting benefits to lower-income people.
Con: An argument against this option is that it would weaken the Social Security system's link between earnings and benefits. In addition, the second approach would reduce benefits for beneficiaries with an AIME above the 45th percentile, some of whom do not have high lifetime earnings. CBO projects that in 2028 the second approach would reduce benefits for people with an AIME higher than about $3,100, or approximately $37,000 in annual indexed earnings.

See CBO Report: https://www.cbo.gov/budget-options/2018/54744

Means-Testing Social Security Benefits

Social Security benefits have always been provided to anyone who has paid into the system and meets the work and age requirements. That's regardless of their other income–investment, pension, savings–the person receives in addition to Social Security benefits (although a portion of Social Security benefits is taxable if the total income exceeds a certain threshold). One option to help close Social Security's funding gap is to "means test." Means testing would reduce benefits for higher-income recipients and could even eliminate benefits altogether for the highest-income households.

Unlike the reform option to reduce benefits for higher earners, which uses a measure of career average earnings to reduce benefits, means testing would reduce benefits based on the full range of current income. Who would be affected and by how much depends on

how the income thresholds are defined? One version of means testing is estimated to fill about 11 percent of the funding gap.

Pro: In an era of scarce resources, Social Security cannot afford to continue to pay benefits to every eligible retiree regardless of what other retirement income they have. One approach to preserving the program would be to provide monthly benefits only to retirees with less than a certain amount of non-Social Security annual income. Those with more income would be guaranteed to start to receive their benefits if their circumstances change. Social Security would continue to be insurance against retirement poverty for everyone. Still, it would focus its benefit payments on those who really need them. There are many ways to apply a means test, but they all preserve scarce benefit dollars by paying them to those who really need the income. No matter what their income level, all taxpayers receive the guarantee that Social Security will be there for them if they need it. That gives everyone something of value for their Social Security payroll taxes.

Con: Means testing Social Security would fundamentally change it from social insurance (a universal system of benefits earned by all who have paid in) to welfare (a system requiring you to prove you are needy to qualify for benefits). As social insurance, Social Security provides a foundation of retirement security, family life insurance, and disability income protection for virtually all-American workers. Benefits are an earned right based on earnings from which premiums are deducted, as payroll taxes. Social Security uses an earnings replacement concept, recognizing that there is a relationship between your standard of living while working and the benefit you need to achieve income security in retirement. The benefit formula already replaces a higher portion of past earnings for low earners than for higher earners. Means testing would likely cut benefits for the broad middle class because only a small share of benefits go to wealthy people. Only 2 percent of benefits are paid to people with more than $100,000 in other income. One plan, which features means testing and other Social Security benefit cuts, illustrates the problem. This plan would shrink total Social Security benefits paid by 45 percent over 25 years. Means testing Social Security would undermine much of its core strength, turning it into an unpopular welfare program while sharply reducing the adequacy of Social Security benefits for middle-class Baby Boomers and younger American workers.

Recalculate the COLA

Cost-of-living adjustments (COLAs) for Social Security and many other parameters of federal programs are indexed to increases in traditional measures of the consumer price index (CPI). Since 1975, Social Security has based such adjustments on the CPI. The CPI measures changes in the prices of consumer goods and services and is calculated by the Bureau of Labor Statistics (BLS). One option to modify Social Security would be to use an alternative price index for calculating the COLA. Currently, the BLS uses two other additions to the traditional measures of CPI:

- *Chained CPI (C-CPI)*. By applying a different formula to the same goods and services data, this index accounts for how consumers change their buying habits when prices change. Experts predict that the annual COLA would be on average

0.25 percentage points lower using the chained CPI. For example, if the current formula produced a 2.0 percent annual COLA, the Chained Consumer Price Index might yield a 1.75 percent COLA. The effect of a lower COLA would compound over time, reducing the benefit by 2.50 percent after 10 years and 6.4 percent after 30 years. Permanently reducing the size of the benefit adjustment every year is estimated to fill 23 percent of the gap; and

- *Elderly Index (CPI-E):* The CPI-E index, developed back in 1987 with the enactment of The Older Americans Act of 1987, directed the Bureau of Labor Statistics to develop an alternative experimental consumer price index for older individuals. The CPI-E considers the spending patterns of older individuals, including their greater spending on health care. The CBO has estimated that the annual COLA would be on average 0.2 percentage points higher under this formula. For example, if the current formula would produce a 2.0 percent annual COLA, the elderly price index might yield a 2.2 percent COLA. In addition, the effect of a higher COLA would compound over time, increasing the benefit by 2 percent after 10 years and 6 percent after 30 years. Permanently increasing the size of the benefit adjustment every year is estimated to increase the funding gap by 16 percent.

Pro: The purpose of Social Security's annual COLA is to protect retirees against inflation, reducing their monthly benefits' purchasing power. Thus, the index used to set the annual COLA must provide the most accurate estimate of inflation. The current use of the CPI-W does not do this. In 1972, when annual automatic COLAs replaced irregular benefit increases passed by Congress (usually during an election year), only one inflation measure was available: the CPI. It measures the inflation experienced by urban wage workers and clerical workers. This index, later renamed CPI-W (for workers), represents only about 32 percent of the total population. Changing the COLA based on a Chained CPI index would be a more accurate measure of cost-of-living changes than the CPI-W because the former but not the latter considers that consumers adjust their goods when certain goods become more expensive spending patterns and substitute different, less expensive goods.

Con: The purpose of Social Security's COLA is to maintain the buying power of benefits when prices rise because of inflation. While some say that switching from the present COLA to one based on a Chained CPI would more accurately measure inflation on average, it would not be more accurate for older people, who differ from younger households because older people spend more out of pocket for health care costs (which rise faster than average inflation). The present COLA already understates the inflation experience by older people. A COLA based on the Chained CPI would make things worse, cutting benefits for all current and future beneficiaries by 0.25 percentage points each year, on average.

Instead of adopting the Chained CPI, policymakers should consider basing the COLA on a CPI that reflects the buying patterns of older people. COLAs based on a CPI for the elderly would go up 0.2 percentage points faster than the current COLA and 0.5 percentage points faster than a COLA based on the proposed chained index. If the purpose of COLA is to maintain the buying power of Social Security for beneficiaries–no

more, no less–an inflation measure that undercounts older people's costs would not meet that goal; a CPI for older people would.

The Social Security 2100 Act, legislation introduced in the House by Rep. John Larson (D.-Conn) would change how COLA is determined by requiring the higher of the CPI-W or the CPI-E to be used in calculating the COLA.

Increase the Payroll Tax Rate

As was discussed in Chapter 2, Social Security is financed primarily by payroll taxes on employers, employees, and the self-employed. Only earnings up to a maximum of $168,600 in the calendar year 2024 are subject to tax. The maximum usually increases each year at the same rate as average wages in the economy. The Social Security tax rate is 12.4 percent of earnings. Employees have 6.2 percent deducted from their paychecks, and their employers pay the remaining 6.2 percent. Self-employed individuals generally pay 12.4 percent of their net self-employment income. This option would increase the Social Security payroll tax rate by 1.0 percentage points. That rate increase would be evenly split between employers and employees. Specifically, the rate for both employers and employees would increase by 0.5 percentage points, to 6.7 percent, resulting in a combined rate of 13.4 percent. The rate paid by self-employed people would also rise to 13.4 percent.

Pro: Arguably, the simplest fix of all would be to increase the payroll tax. Increasing the payroll tax on all American workers would generate additional income and possibly make benefit cuts unnecessary, at least through 2091. The changes would affect all covered workers and would not change benefits. The cost for an average earner would be less than $4 in additional contributions each week (on top of their employer's additional contribution of the same amount).

Con: Social Security's payroll tax is regressive because of its flat rate and cap, so low- and moderate-income taxpayers pay more of their income in payroll tax than high-income people, on average.

Increase the Payroll Tax Cap

The payroll tax earnings cap is always of particular interest given the debate around whether the well-to-do should pay more into the Social Security program. In 2024, all earned income between $0.01 and $168,600 is subject to the Social Security 12.4% payroll tax. What is "earned income"? Earned income is defined as wages and salary, with all forms of investment income not included. All earned income above $168,600 is exempt from the payroll tax. This cap generally increases every year as the national average wage increases (NAWI). Raising the cap to cover a higher percentage of total earnings would help close Social Security's funding gap. How much depends on how high the cap is set and how quickly the cap would be raised to reach that level. One commonly mentioned goal would be to raise the cap to cover 90 percent of all earnings. This would mean an employee earning more than the 2024 tax cap of $168,600 (and their

employer) would have to pay more payroll taxes. Raising the cap to 90 percent is estimated to fill 36 percent of the funding gap.

Pro: Lifting the cap on earnings subject to Social Security taxes to cover 90 percent would complete the job that Congress started in 1977 when it set the cap to include 90 percent of the earnings of all covered workers. Congress also adjusted the cap automatically to keep pace with average wage growth to continue to cover 90 percent of earnings. Because of growing inequality since then, with today's top earners enjoying much bigger gains than everyone else, the cap now covers only about 84 percent of all earnings. Lifting the cap to 90 percent is sensible and fair. Only 6 percent of workers earn more than the current cap of $168,600. If phased in over five years, restoring the cap to include 90 percent of all earnings (or about $279,300 a year) and counting those earnings toward the worker's future benefits would provide the following benefits: Restore the intent of Congress; Make Social Security financing fairer by requiring top earners to pay somewhat more into Social Security, and eliminate more than a third (36 percent) of Social Security's projected financing gap over the long-term.

Note: The fact that most working Americans are paying into Social Security with every dollar they earn while the well-to-do may only be paying into the program on a fraction of their income has some folks calling for an increase or elimination of the maximum taxable earnings cap.

Con: The bad news about this idea is that it would cause a hefty tax increase that will hit middle-income taxpayers while not affecting the rich. It would hurt the self-employed and certain smaller business owners. Such a move only delays Social Security's financial problems. The proposal would mean that people would pay Social Security payroll taxes on their first $215,000 of income instead of today's $168,600 level. If accepted, this move would hit employees with up to $2,877 in new taxes each year (assuming a 6.2% employee FICA tax). What is worse, the self-employed and certain small business owners would see up to a $5,754 annual tax increase. In general, increasing taxes is a bad idea.

For one thing, it reduces the amount that Americans must spend on their own and their family's food, housing, clothes, education, and so on. Additional taxes that seem like a trivial amount to people in Washington may cause real problems for normal Americans. It has been projected this tax increase delays Social Security's problems by only eight years while hurting middle-class Americans. It does not fix the problem.

Social Security 2100: A Sacred Trust

Back in October 2021, the House Ways, and Means Social Security Subcommittee Chairman John B. Larson (D.-CT) introduced Social Security 21—A Sacred Trust. The legislation has nearly 200 cosponsors and has been endorsed by more than 100 advocacy groups. Below is information from the actual Bill.

Title I Strengthening Benefits

Section 101. Across-the-board benefit increase. Provides an immediate benefit increase for all beneficiaries of $30 a month, representing a 2 percent benefit increase for the average retiree. Effective in 2024-2026 for all beneficiaries.

Section 102. More accurate cost-of-living adjustment. Improves the annual cost-of-living adjustment (COLA) by basing it on a consumer price index for the elderly (CPI-E), which measures the cost increases experienced specifically by seniors. The CPI-E is projected, on average, to be higher than the CPI-W by 0.2 percentage points per year. Improved inflation protection will especially help older retirees and widows who are more likely to rely on Social Security benefits as they age. Effective for COLAs in December 2024 through December 2026.

Section 103. Increasing the minimum benefit for long-term low earners. Protects long-serving, low-income workers by updating the "special minimum benefit" so that people who worked and paid into Social Security for many years, even at low wages, can be kept out of poverty by their Social Security benefit. For instance, someone who works 30 years and retires at full retirement age would receive a benefit that is 125% of the poverty line. The new minimum benefit is tied to wage levels to ensure it does not fall behind in future years. Effective in 2024-2026 for individuals who first become eligible for benefits during those years.

Section 104. Increasing threshold amounts and rate for inclusion of Social Security benefits in income. Raises the income threshold above which Social Security must be included in a beneficiary's income for tax purposes. Social Security benefits are taxed when beneficiaries have other income in addition to their benefits if their income exceeds certain thresholds. These thresholds are currently $25,000 for individuals and $32,000 for couples; this provision raises the thresholds to $35,000 and $50,000, respectively. Medicare's Hospital Insurance trust fund, which receives some revenue from this taxation, is held harmless. Effective for taxable years 2024-2026.

Section 105. Improving benefits for widows and widowers in two-income households. Ensures that widow(er)s receive 75 percent of the combined Social Security benefits the couple received prior to one spouse's death. This is because, in dual-earner couples, the household's Social Security income can be significantly reduced when one member dies; for couples with similar earnings histories, the reduction can be as much as half. The new benefit is capped at the benefit for a lifelong average earner to target the improvements to lower-earning couples. Effective in 2024-2026 for all widow(er)s receiving benefits.

Section 106. Increasing benefits for beneficiaries after 15 years of eligibility. Provides an across-the-board benefit increase for the oldest old and other long-term beneficiaries. The full amount of the increase–5 percent of the benefit amount for a lifelong average earner – is paid starting with the 20th year after each person's benefit eligibility began. The increase phases in during the 16th through 20th year after eligibility. Effective in 2024-2026 for all beneficiaries who have been receiving benefits for more than 15 years.

Section 107. Providing caregiver credits for Social Security. Provides an earnings credit within the Social Security benefit formula for up to 5 years for someone out of the workforce or with reduced wages while caring for a child under age 12 or a dependent relative. Because Social Security benefits are based on 35 years of earnings, people who leave the workforce or reduce their work hours to care for children or other family members often suffer a reduction in their benefits. For caregivers with no earnings during these years, the earnings credits would bring their wage record for the 5 years up to a level that is equal to half the national average wage; caregivers with some earnings would also receive credits, with amounts that phase out as they approach the average wage level. Effective in 2024-2026 for anyone receiving benefits who has a prior year(s) of caregiving.

Section 108. Eliminating the 5-month waiting period for disability benefits. Eliminates the waiting period (currently 5 months, except for individuals with ALS) to receive Social Security disability benefits. Instead, individuals who qualify for these benefits based on a severe disability are eligible for them beginning with the date their disability starts. Effective for individuals who first become eligible for benefits during 2024-2026.

Section 109. Establishing a gradual offset for disability beneficiaries with earnings. Replaces the current "benefit cliff" for disability benefits with a gradual offset that applies after the Trial Work Period ends. Instead of benefits ending altogether when a disabled beneficiary earns above a threshold for a sustained period, this provision creates a gradual offset such that benefits are reduced by $1 for every $2 of earnings above a threshold, which is set for all beneficiaries at the "substantial gainful activity" level for blind individuals (currently $2,590 a month in 2024). Effective for all earnings in 2024-2026.

Section 110. Repealing the government pension offset and windfall elimination provisions. Repeals the Government Pension Offset (GPO) and Windfall Elimination Provision (WEP) so that affected state and local government retirees are no longer subject to these reductions in their Social Security benefits. Effective for benefits paid in 2024-2026 to those affected by WEP and GPO.

Section 111. Extending the child's benefit for post-secondary school students under age 26. Restores student benefits up through age 25 for the children of disabled, deceased, or retired workers if they are at least half-time college or vocational school students. Currently, child benefits end at age 18 (or 19, if a full-time high school student); prior to 1981, full time-students under age 22 could receive benefits. Effective in 2024-2026 for qualifying students.

Section 112. Increasing access to benefits for children who live with grandparents or other relatives. It makes dependent benefits more widely available to children living with (and 3 dependents on) their grandparents or other Social Security relatives. Currently, such dependent benefits are restricted to limited circumstances, and these restrictions do not reflect the realities of many family structures. Effective in 2024-2026 for qualifying children.

Section 113. Preventing an unintended drop in benefits relating to the application of the National Average Wage Index. Corrects a flaw in the benefit formula that causes an unintentional and permanent benefit reduction for some beneficiaries if the average wage index drops in any year. Instead, the average wage index as used for these benefit purposes would simply be prevented from dropping from one year to the next – consistent with protections already in place for other parameters of Social Security. Effective in 2024 and all future years.

Section 114. Holding SSI, Medicaid, and CHIP beneficiaries harmless. Ensures that any increase in benefits from the bill does not result in a reduction in Supplemental Security Income (SSI) benefits or loss of eligibility for Medicaid or CHIP.

Title II Strengthening the Trust Fund

Section 201. Determining wages and self-employment income above contribution and benefit base after 2024; and

Section 202. Including earnings over $400,000 in the Social Security benefit formula. Applies the Social Security payroll tax to earnings above $400,000. Currently, only earnings up to the tax cap ($168,800 in 2024, an amount which is adjusted for rising wage levels each year) are taxed for Social Security. The $400,000 threshold is fixed so that over time, the tax cap will rise to meet it; thereafter, all earnings will be subject to the Social Security payroll tax, as they already are with the Medicare payroll tax. Newly taxed earnings are counted toward benefits at a 1 percent rate. Includes a conforming change to ensure no effect on the Average Wage Index used to adjust program parameters. Effective in 2024 and all future years.

Section 203. Establishing the Social Security Trust Fund. Combines Social Security's two separate trust funds – for retirement and survivor insurance and disability insurance– into one unified Social Security Trust Fund to ensure that all benefits will be paid. Effective in 2024 and all future years.

Title III Strengthening Service Delivery

Section 301. Clarifying the requirement to mail social security account statements. Improves knowledge of Social Security benefits and assists in retirement planning by clarifying that the Social Security Administration must mail an annual Social Security Statement to all workers aged 25 and older who are not receiving benefits unless a worker chooses electronic delivery. Effective for Statements that must be mailed in 2024 and later.

Section 302. Preventing closure of field and hearing offices and resident or rural contact stations. This prevents the Social Security Administration from reducing the number of field offices below the level in operation at the end of the fiscal year 2024 and bars any field office closure unless certain requirements are met, including advance public notice, opportunities for public input, and robust consideration of the burdens that the closure would place on individuals served by the office. Effective in 2024 and all future years.

Section 303. Ensuring access to professional representation. Increases access to an attorney and other professional representation for individuals needing legal assistance to appeal a denial of disability benefits by increasing the cap on the allowable fees charged by the representative. The dollar amount of the cap – currently $6,000 – would instead be wage-indexed in future years from when it was originally set in 1991. (The cap limiting the total fee to 25 percent of the past-due benefit amount is unchanged.). Effective for fee agreements entered in 2024 and later.

The Social Security Expansion Act

The Social Security Expansion Act introduced February 2023, by Senators Bernie Sanders, I-Vermont, and Elizabeth Warren, D-Massachusetts, aims to make Social Security solvent through the end of the 21st century, while also enhancing benefits.

The Social Security Expansion Act would:

- Extend the solvency of Social Security for 75 years by requiring the wealthiest American households to pay their fair share of taxes. Today, because of the earnings cap on Social Security taxes, a CEO making $20 million a year pays the same amount of money into Social Security as someone who makes $168,600 a year. This legislation would lift this cap and subject all income above $250,000 to the Social Security payroll tax. Under this bill, over 93 percent of households would not see their taxes go up by one penny.
- Expand Social Security benefits across-the-board for current and new beneficiaries. Under this bill, Social Security benefits for current and existing recipients would be increased by $2,400 a year.
- Increase Cost-Of-Living-Adjustments (COLAs). This bill would more accurately measure the spending patterns for seniors by adopting the Consumer Price Index for the Elderly (CPI-E). Older Americans, by and large, are not going out on spending sprees buying big screen TVs, laptops, or the latest high-tech gadgets. Rather, they spend a disproportionate amount of their income on health care and prescription drugs, which would be reflected in the formula for calculating COLAs under this legislation.
- Require millionaires and billionaires pay their fair share into Social Security. Currently, workers have 12.4 percent taken out of each paycheck and contributed to the Social Security trust fund, half paid by the employer and half by the worker. This bill would require the wealthy to pay the same 12.4 percent on their investment and business income, by increasing the net investment income tax by 12.4 percent and applying it to certain business income not already covered by payroll taxes.
- Improve the Special Minimum Benefit for Social Security recipients. This bill would help low-income workers stay out of poverty by increasing the Special Minimum Benefit and indexing the benefit level so that it is equal to 125 percent of the poverty line, or over $18,000 for a single worker who had worked their full career.

- Restore student benefits up to age 22 for children of disabled or deceased workers if the child is a full-time student in a college or vocational school. This legislation would restore student benefits to help educate children of deceased or disabled parents that were eliminated in 1983.
- Combine the Disability Insurance Trust Fund with the Old Age and Survivors Trust Fund to help senior citizens and people with disabilities.

There are 56 groups who endorsed the bill:

1. Social Security Works
2. AFA CWA
3. AFSCME
4. Alliance for Retired Americans
5. American Federation of Government Employees
6. American Federation of Teachers
7. American Postal Workers Union
8. BMWED/IBT
9. International Federation of Professional and Technical Engineers (IFPTE)
10. United Electrical, Radio & Machine Workers of America (UE)
11. United Food and Commercial Workers International Union
12. National Education Association
13. Indivisible
14. MoveOn
15. National Domestic Workers Alliance
16. People's Action
17. Public Citizen
18. Care in Action
19. CASA
20. Center for Medicare Advocacy
21. Center for Popular Democracy
22. Blue Future
23. Church World Service
24. CommonDefense.us
25. Connecticut Citizen Action Group
26. Demand Progress
27. Health Care Awareness Month
28. Hunger Free America
29. Iowa Citizens for Community Improvement
30. Just Care USA
31. National Partnership for Women & Families
32. NETWORK Lobby for Catholic Social Justice
33. NJ State Industrial Union Council
34. Oregonizers
35. Our Revolution
36. Right to Health Action (R2H Action)
37. Sunrise Movement
38. The National Employment Law Project

39.Upper West Side Action Group: MoveOn/Indivisible/SwingLeft
40.Working Families Party
41. National Korean American Service & Education Consortium (NAKASEC)
42.Indivisible Marin
43.Children's Aid
44.P Street
45.East New York Farms
46.Partners for Dignity & Rights
47. Generations United
48.Broadway Community, Inc.
49.National Council of Jewish Women
50.New York State Public Health Association
51. Justice in Aging
52.National Women's Law Center
53.Americans for Tax Fairness
54.National Committee to Preserve Social Security and Medicare
55. Labor Campaign for Single Payer
56. American Medical Student Association.

Since the bill would raise taxes, it must be formally introduced first in the House of Representatives. Sponsored in the House by Representatives Jan Schakowsky, D-Illinois, the bill was referred to the House Committee on Ways and Means on Tuesday. The bill has 26 co-sponsors in the House, as of today, all of whom are Democrats. Republicans control the House, and the Committee on Ways and Means is chaired by Representative Jason Smith, R-Missouri

A statement from Sanders' office said the bill would make Social Security solvent for at least the next 75 years, based on a study

According to a study conducted by Stephen Goss, the chief actuary at the Social Security Administration., he reported:

> *"We estimate that enactment of the provisions in the above Bill would extend the ability of the OASDI program to pay scheduled benefits in full and on time throughout the 75-year projection period. The date of projected depletion of the combined OASI and DI Trust Fund reserves is 2035 under current law and the intermediate assumptions of the 2022 Trustees Repo."*

This proposal includes nine provisions with direct effects on the OASDI program. The following list briefly describes these provisions:

Section 2. Increase the first primary insurance amount (PIA) bend point above the current law level and increase the first PIA factor from 90 to 95, for all OASDI benefits payable based on eligibility for January 2024 and thereafter. Increase the first PIA bend point by 22 percent for benefits payable for eligibility in 2024 and later, regardless of when any beneficiary became initially eligible. Increase the first PIA factor by 5 percentage points, for a PIA factor of 95 percent for benefit eligibility in 2024 and later.

Section 3. Use the increase in the Consumer Price Index for the Elderly (CPI-E) rather than the increase in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) to calculate the cost-of-living adjustment (COLA), effective for December 2025 and later COLAs. We assume this change would increase the COLA by an average of 0.2 percentage point per year.

Section 4. Increase the special minimum PIA for workers who become newly eligible for retirement or disability benefits or die in 2024 or later. For workers becoming newly eligible or dying in 2024, the minimum initial PIA for workers with 30 or more years of coverage (YOCs) is 125 percent of the annual poverty guideline for a single individual, as published by the Department of Health and Human Services for 2023, divided by 12. For workers becoming newly eligible or dying after 2024, the minimum initial PIA increases by the growth in the national average wage index (AWI).

Section 5. Continue benefits for children of disabled, or deceased workers until they attain age 22 if the child is in high school, college, or vocational school, beginning in 2024.

Sections 6 and 7. Apply the combined OASDI payroll tax rate on earnings above $250,000, effective for 2024 and later. Tax all earnings once the current-law taxable maximum exceeds $250,000. Do not credit the additional taxed earnings for benefit purposes.
Section 8a. Apply a separate 12.4-percent tax on investment income as defined in the Affordable Care Act (ACA), payable to the OASI and DI Trust Funds with unindexed thresholds as in the ACA, effective for 2024 and later. The ACA thresholds are $200,000 for a single filer and $250,000 for a married couple filing jointly. Under this provision, there is no limit on the amount taxed.

Section 8b. Apply a 16.2-percent net investment income (NII) tax on active S-corporation holders and active limited partners, effective for 2024 and later. Of the total 16.2 percent tax, 12.4 percentage points would be payable to the OASI and DI Trust Funds, and 3.8 percentage points would be payable to the General Fund of the Treasury.

Section 9. Combine the current separate Old-Age and Survivors Insurance (OASI) and Disability Insurance (DI) Trust Funds into a single Social Security Trust Fund, effective January 1, 2024

You can get more detailed information at:
https://www.sanders.senate.gov/wp-content/uploads/SandersLetter-2023-0213.pdf

Further Reading

Center for Retirement Research at Boston College; Working Papers, How To Pay for Social Security's Missing Trust Fund?; December 2017; https://crr.bc.edu/working-papers/how-to-pay-for-social-securitys-missing-trust-fund/

Congressional Budget Office (CBO); "*Make Social Security's benefit Structure More Progressive*;" (December 13, 2018); https://www.cbo.gov/budget-options/2018/54744

American Academy of Actuaries, Issue Brief, October 2023
pension-brief-social-security-reform-sooner.pdf (actuary.org)

Social Security 2100: A Sacred Trust, The Bill
https://larson.house.gov/sites/larson.house.gov/files/LARSON_021_xml%2010.26.21%20FINAL%20BILL%20TEXT.pdf

Social Security 2100: A Sacred Trust Fact Sheet
https://larson.house.gov/sites/larson.house.gov/files/Social%20Security%202100%20-%20Fact%20Sheet%20117th.pdf

The Social Security Expansion Act
https://www.sanders.senate.gov/wp-content/uploads/Social-Security-Expansion-Act-one-pager-Final.pdf

Social Security Office of the Chief Actuary
https://www.sanders.senate.gov/wp-content/uploads/SandersLetter-2023-0213.pdf

Chapter 9
Review Questions

1. All excess funds in the trust funds can only be invested in which of the following investments?

( ) A. Interest-bearing securities of the U.S. Government
( ) B. U.S. Equities
( ) C. Corporate bonds
( ) D. Certificates of Deposit

2. How many Trustees oversee the Social Security Trust Fund?

( ) A. 2
( ) B. 6
( ) C. 4
( ) D. 8

3. The payroll tax cap covers about what percent of total earnings in the nation?

( ) A. 100%
( ) B. 20%
( ) C. 84%
( ) D. 45%

4. According to the 2025 SSA Trustees Report, the combined OASDI Trust Fund reserves will deplete in what year?

( ) A. 2030
( ) B. 2034
( ) C. 2028
( ) D. 2059

5. Which Index considers the spending patterns of older individuals, including their greater spending on health care?

( ) A. CPI- U
( ) B. CPI-W
( ) C. CPI-E
( ) D. Chained CPI

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SECTION TWO

MEDICARE

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CHAPTER 10

INTRODUCTION TO MEDICARE

Overview

Medicare is a federal insurance program that pays for the covered healthcare services of qualified beneficiaries. While commonly known as Medicare, it was established in 1965 under Title XVIII–Health Insurance for the Aged and Disabled within the Social Security Act as a federal entitlement program. As part of the Social Security Amendments signed into law by President Lyndon B. Johnson in 1965, the Medicare legislation established a health insurance program for aged persons that would complement the retirement, survivors, and disability insurance benefits created under Title II of the Social Security Act.

This chapter will begin with a review of the historical background of the Medicare program. Then examine the various parts of the Medicare program, the administration, the eligibility requirements, and the choice between Original Medicare and a Medicare Advantage plan (Part C). At the end of the chapter, we'll examine the finances of the two Medicare Trust Funds (HI and SMI) and review the short-range and long-range conclusions of the 2025 Medicare Trustees Report.

Learning Objectives

Upon completion of this chapter, you will be able to:

- Relate the history and the administration of the Medicare program.
- Identify the various parts of Medicare: Part A, Part B, Part C, and Part D.
- Distinguish the differences in coverage between traditional Medicare and Medicare Advantage (Part C).
- Describe the Medicare Trust funds; and
- Explain the short-term and long-term financial outlook of the Medicare program.

History of Medicare

Medicare was established in 1965 as a federal insurance program to provide what the private insurance market did not: adequate, affordable health insurance for America's elderly population regardless of income or health status. Prior to Medicare, only half of the population aged 65 and older had health insurance. Even among those 65 and older

who were insured, premiums and other out-of-pocket costs were close to three times what younger people paid, even though the elderly had on average only half as much income.

Since 1965, the Medicare program has undergone considerable change. The Patient Protection and Affordable Care Act (ACA) of 2010 (ACA, P.L. 111-148 as amended) made numerous changes to the Medicare program. It is important to remember that the Medicare program is an entitlement program, which means that it is required to pay for covered services provided to enrollees so long as specific criteria are met. Currently, Medicare is the nation's largest health insurance program, accounting for one in five health care dollars, and currently accounts for 15 percent of the federal budget. This figure is expected to reach 17.5 percent by 2027. According to the *2025 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, in 2024, Medicare covered 67.6 million people: 60.3 million aged 65 and older, and 7.3 million disabled (see Table 10.1).

Table 10.1
Medicare Enrollment (1996-2024)

Year	Total Persons	Aged Persons	Disabled
1966	19.1	19.1	--
1970	20.4	20.4	--
1975	24.9	22.7	2.2
1980	28.4	25.5	3.0
1985	31.1	28.1	2.9
1990	34.3	31.0	3.3
1995	37.6	33.2	4.4
2000	39.7	34.3	5.4
2005	42.6	35.8	6.8
2010	47.7	39.6	8.1
2015	55.3	46.3	9.0
2016	56.8	47.8	9.0
2017	58.4	49.5	8.9
2018	59.9	51.2	8.8
2019	61.2	52.6	8.7
2020	62.6	54.1	8.5
2021	63.8	55.5	8.3
2022	65.0	57.1	7.9
2023	66.7	59.1	7.6
2024	67.6	60.3	7.3

Note: Represents those enrolled in HI (Part A) and/or SMI (Part B and Part D). Numbers may not add to totals because of rounding. Based on the 2025 Trustees Report.
Source: https://www.cms.gov/oact/tr/2025

Medicare Administration

The Department of Health and Human Services (DHHS) has the overall responsibility for the administration of the Medicare program. Within the Department of Health and Human Services (DHHS), responsibility for administering Medicare rests with the Centers for Medicare & Medicaid Services (CMS), whose central office is in Baltimore, Maryland.

The Social Security Administration (SSA) offices assist, however, by initially determining an individual's Medicare entitlement; withholding Part B premiums from the Social Security benefit checks of most beneficiaries; providing general information about the program, and maintaining Medicare data on the master beneficiary record, which is the Social Security Administration's primary record of beneficiaries. The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) requires Social Security Administration (SSA) to undertake a number of additional Medicare-related responsibilities, including making low-income subsidy determinations under Part D; notifying individuals of the availability of Part D subsidies, withholding Part D premiums from monthly Social Security cash benefits for those beneficiaries who request such an arrangement; and, for 2007 and later, making determinations as to the amount of the individual's Part B premium if the income-related monthly adjustment applies. The Internal Revenue Service (IRS) in the Department of the Treasury collects the Part A payroll taxes from workers and their employers. IRS data, in the form of income tax returns, plays a role in determining which Part D enrollees are eligible for low-income subsidies (and to what degree); and, for 2007 and later, which Part B enrollees are subject to the income-related monthly adjustment amount (IRMAA) in their premiums (and to what degree).

Medicare Parts

Medicare originally consisted of two parts:

- Hospital Insurance (HI), also known as Part A; and
- Supplementary Medical Insurance (SMI), which in the past was also known simply as Part B.

Original Medicare: Part A and Part B

Original Medicare comprises Part A and Part B. Part A helps pay for inpatient hospital, home health, skilled nursing facility, and hospice care. Part A is provided free of premiums to most eligible people; certain otherwise ineligible people may voluntarily pay a monthly premium for coverage (see Chapter 11 for a full discussion of Part A). Part B helps pay for physicians, outpatient hospitals, home health, and other services. To be covered by Part B, all eligible beneficiaries must pay a monthly premium (see Chapter 12 for a full discussion of Part B).

Medicare Part C

The third part of Medicare, sometimes known as Part C, is the Medicare Advantage program, which was established as the Medicare+Choice program by the Balanced Budget Act (BBA) of 1997 (Law 105-33) and subsequently renamed and modified by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173). The Medicare Advantage program expands beneficiary options for participation in private-sector health care plans (see Chapter 13 for a full discussion of Part C).

Medicare Part D

The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 also established a fourth part of Medicare, known as Part D, to help pay for prescription drugs not otherwise covered by Original Medicare (Part A and/or Part B). Part D initially provided access to prescription drug discount cards, voluntarily and at a limited cost, to all enrollees (except those entitled to Medicaid drug coverage) and, for low-income beneficiaries, transitional limited financial assistance for purchasing prescription drugs and a subsidized enrollment fee for the discount cards. This temporary plan began in mid-2004 and was phased out during 2006. In 2006 and later, Part D provides subsidized access to prescription drug insurance coverage voluntarily, upon payment of premium, for all beneficiaries, with premium and cost-sharing subsidies for low-income enrollees (see Chapter 14 for a full discussion of Part D).

Note: Part D activities are overseen within the SMI Trust Fund but in an account separate from Part B. It should thus be noted that the traditional treatment of "SMI" and "Part B" as synonymous is no longer accurate since SMI now consists of both Parts B and D. The purpose of the two separate accounts within the SMI Trust Fund is to ensure that funds from one part are not used to finance the other.

Medicare Eligibility

When first implemented in 1966, Medicare covered most persons aged 65 or over, as discussed above. In 1973, the following groups also became eligible for Medicare benefits:

- Persons entitled to Social Security or Railroad Retirement disability cash benefits for at least 24 months.
- Most persons with end-stage renal disease (ESRD); and
- Certain otherwise non-covered aged persons elect to pay a premium for Medicare coverage.

Beginning in July 2001, people with Amyotrophic Lateral Sclerosis (Lou Gehrig's disease) are allowed to waive the 24-month waiting period.

Applying for Medicare Benefits

Medicare benefits become available at the beginning of the beneficiary's birth month upon reaching their 65th birthday. This is true even if the beneficiary is still working. If they are eligible, they will receive their Medicare card (red, white, and blue) in the mail 3 months before their 65th birthday. Medicare benefits are also available after an individual has been receiving Social Security Disability Insurance (SSDI) benefits for two years (receive their Medicare card on their 25th month of disability) or has end-stage renal disease (ESRD) requiring renal dialysis or a kidney transplant.

If a beneficiary doesn't want Part B, they must follow the instructions that come with the card and send the card back. If the beneficiary keeps the card, they keep Part B and pay the Part B premiums (discussed below).

Note: The best and official source of answers to many Medicare questions can be found in the "*Medicare and You 2025*" booklet. To download a copy, visit https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf

Choosing Medicare Coverage

There are two main choices an individual, who qualifies for Medicare, can choose to receive Medicare coverage. They are:

- Original Medicare (Medicare Part A and Part B); or
- Medicare Advantage Plan (Part C).

Here are the following steps a Medicare beneficiary must take to choose their Medicare program. In the following chapters, the words "beneficiary, they, their(s), he/she, and patient, etc." means the "person enrolling for coverage."

Step 1: Decide as beneficiary which option of coverage:

A. Original Medicare:
   - Part A (HI); and
   - Part B (MI).

   Or

B. Part C: Medicare Advantage Plan (like an HMO or PPO):
   - Combines Part A, Part B, and usually Part D.

Step 2: Decide if the beneficiary needs drug coverage (Part D):

- Medicare Prescription Drug Plan; or
- Medicare Advantage with Drug Plan (MA-PD).

Step 3: Decide if the beneficiary needs to add supplemental coverage to their Original Medicare. **Note:** If beneficiary joins a Medicare Advantage Plan, they will not need (and can't be sold) a Medicare Supplement policy (also known as Medigap).

Number of People Enrolled in Medicare

In 2024, Medicare covered 67.6 million people: 60.3 million aged 65 and older, and 7.3 million disabled. About 50 percent of those beneficiaries have chosen to enroll in Part C private health benefits that contract with Medicare to provide Part A and Part B health services.

Table 10.2 displays the projected average monthly enrollment during the fiscal year 2024. According to the CMS Office of the Actuary, it projects that 99.3 percent of the total persons in the Medicare program (beneficiaries) participate in Part A, 91.7 percent participate in Part B, and 81.7 percent participate in Part D.

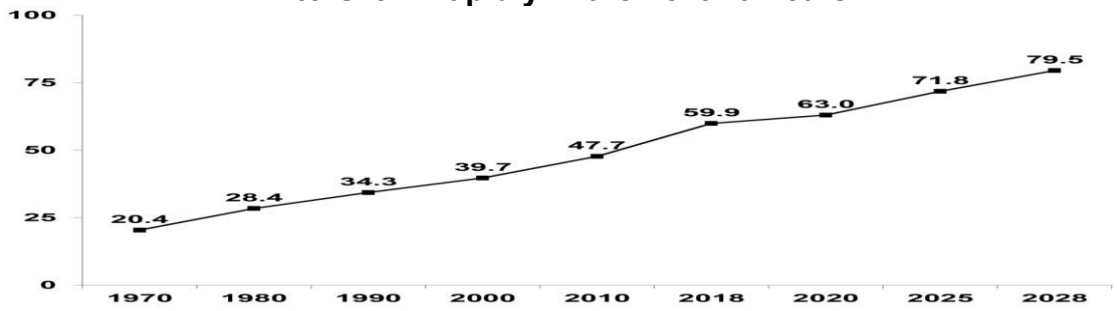
Table 10.2
Medicare Enrollments FY 2024

	HI or Part A	SMI		
		Part B	Part D	Total
All persons	67.2	62.0	55.2	67.6
Aged persons (65 and older)	59.9	55.2	49.0	60.3
Disabled persons	7.3	6.8	6.2	7.3

Source: 2025 Trustees Report
Source: 2025 Medicare Trustees Report (cms.gov)

The CMS Office of the Actuary projects that the total number of people enrolled in the Medicare program will increase to 80 million in 2028 (see Table 10.3). The increase in Medicare enrollment will accelerate until 2030 as more members of the Baby-Boomer generation have become eligible.

Table 10.3
Enrollment in Medicare Program is Projected to Grow Rapidly in the next 20 Years



Source: CMS Office of the Actuary, 2022 Trustees Report
https://www.ssa.gov/oact/TR/2021/tr2022.pdf

Medicare Trust Funds

The Social Security Act established the Medicare Board of Trustees to oversee the financial operations of the two trust funds:

- The Hospital Insurance (HI) Trust Fund for Part A; and
- The Supplementary Medicare Insurance (SMI) Trust Fund for Parts B and D.

The Board has six members. Four members serve by virtue of their positions in the Federal Government:

- The Secretary of the Treasury (the Managing Trustee).
- The Secretary of Labor.
- The Secretary of Health and Human Services; and
- The Commissioner of Social Security.

Two other members are public representatives whom the President appoints, and the Senate confirms. These positions have been vacant since 2015. The Administrator of the Center for Medicare and Medicaid Services (CMS) serves as Secretary of the Board.

The Social Security Act requires that the Board, among other duties, report annually to Congress on the financial and actuarial status of the HI and SMI Trust Funds.

The 2025 Medicare Trustees Report

The 2025 Medicare Trustees report, "*The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*," is the 60th that the board submitted and released to the public on June 18, 2025.

In 2024, 2024, Medicare covered 67.6 million people: 60.3 million aged 65 and older, and 7.3 million disabled. About 50 percent of these beneficiaries have chosen to enroll in Part C private health plans that contract with Medicare to provide Part A and Part B health services.

Total Medicare expenditures in 2024 were $1,122.1 billion, and total income was $1,1333.3 billion, which consisted of $1,122.3 billion in non-interest income and $11.0 billion in interest earnings.

This $11.2 billion difference means assets held in special issue U.S. Treasury securities increased to $407.9 billion (see Table 10.4).

Table 10.4
Medicare Data for Calendar Year 2024

		SMI		
	HI or Part A	Part B	Part D	Total
Assets at end of 2022 (billions)	$208.8	$172.2	$15.7	$396.7
Total Income	$451.2	$532.9	$149.3	$1,133.3
Payroll taxes	$396.4	-	-	$396.4
Interest	$7.2	$3.5	$0.3	$11.0
Taxation of benefits	$39.8	-	-	$39.8
Premiums	$5.0	$140.1	$19.3	$164.4
General revenue	$1.6	$386.0	$111.6	$498.7
Transfer from States	-	-	$18.0	$18.0
Other	$1.6	$3.2	$0.2	$5.0
Total expenditures	$422.5	$553.4	$146.2	$1,122.1
Benefits	$416.3	$547.8	$145.7	$1,109.8
Hospital	$144.4	$80.5	-	$225.0
Skilled nursing facility	$28.5	-	-	$28.5
Home health care	$5.9	$10.0	-	$15.9
Physician fee schedule	-	$71.4	-	$71.4
Private health plans (Part C)	$192.5	$301.6	-	$494.0
Prescription drugs	-	-	$145.7	$145.7
Other	$44.9	$84.3	-	$129.2
Administrative expenses	$6.2	$5.6	$0.5	$12.2
Net change in assets	$28.7	-$20.5	$3.1	$11.2
Assets at end of 2022	$237.5	$151.7	$18.8	$407.9
Enrolled (millions)				
Aged	59.9	55.2	49.0	60.3
Disabled	7.3	6.8	6.2	7.3
Total	67.2	62.0	55.2	67.6
Average benefit per enrollee	$6,193	$8,831	$2,638	$16,710

[1]Calculated as the sum of the Part A, Part B, and Part D amounts.
Note: Totals do not necessarily equal the sums of rounded components.
Source: 2025 Trustees Report
Source: 2025 Medicare Trustees Report (cms.gov)

Short-Range Results

The estimated depletion date for the HI trust fund is 2033, 3 years earlier than projected last year primarily due to the change in projected expenditures. HI expenditures through the short-range period are projected to be higher than last year's estimates. This increase is mainly a result of higher-than-anticipated 2024 expenditures and higher projected spending for inpatient hospital and hospice services.

In 2024, HI income exceeded expenditures by $28.7 billion. The Trustees project that surpluses will continue through 2027, followed by deficits until the trust fund becomes depleted in 2033. The assets were $237.5 billion at the beginning of 2025, representing

about 53 percent of expenditures projected for 2025, which is below the Trustees' minimum recommended level of 100 percent.

The HI trust fund has not met the Trustees' formal test of short-range financial adequacy since 2003. Growth in HI expenditures has averaged 5.2 percent annually over the last 5 years, compared with non-interest income growth of 6.9 percent. Over the next 5 years, projected average annual growth rates for expenditures and noninterest income are 7.4 percent and 5.1 percent, respectively.

The SMI trust fund is expected to be adequately financed over the next 10 years and beyond because income from premiums and Federal Government contributions for Parts B and D are reset each year to cover expected costs and ensure a reserve for Part B contingencies. The monthly Part B premium for 2025 is $185.00.

Part B and Part D costs have each averaged an annual growth rate of 8.4 percent over the last 5 years, as compared with the Gross Domestic Product (GDP) growth rate of 6.1 percent. The Trustees project that cost growth over the next 5 years will average 8.8 percent for Part B and 7.1 percent for Part D, faster than the projected average annual GDP growth rate of 4.2 percent over the period.

As required by law, the Trustees are issuing a determination of projected excess general revenue Medicare funding in this report because the difference between Medicare's total expenditures and its dedicated financing sources7 is projected to exceed 45 percent of expenditures within 7 years. Since this determination was made last year as well, this year's determination triggers a Medicare funding warning, which requires the following:

- The President to submit to Congress proposed legislation to respond to the warning within 15 days after the Fiscal Year 2027 Budget submission; and
- Congress to consider the legislation on an expedited basis.

This is the ninth consecutive year that a determination of excess general revenue Medicare funding has been issued, and the eighth consecutive year that a Medicare funding warning has been issued.

Long-Range Results

For the 75-year projection period, the HI actuarial balance has decreased to −0.42 percent of taxable payroll from −0.35 percent in last year's report. (Under the illustrative alternative projections, the HI actuarial balance would be −1.28 percent of taxable payroll.) Several factors contributed to the change in the actuarial balance, most notably the following:

- Higher-than-estimated 2024 expenditures (−0.09 percent);
- Changes to hospital and hospice growth assumptions (−0.12 percent); and
- Changes to economic and demographic assumptions (+0.15 percent).

Part B expenditures were 1.9 percent of GDP in 2024.

The Board projects that they will grow to about 4.2 percent by 2099 under current law. The long-range projections as a percent of GDP are higher than those projected last year because of higher projected spending for outpatient hospital and physician-administered drugs. (Part B costs in 2099 would be 5.3 percent of GDP under the illustrative alternative scenario.) The Board estimates that Part D expenditures will increase from 0.5 percent of GDP in 2024 to about 0.6 percent by 2099. For Part D, the expenditure share of GDP is lower than the share in last year's report in most years. This is the case because Part D enrollment is lower than projected in last year's report, and it is disproportionately lower for those eligible for low-income subsidies.

The vast majority of SMI income consists of government contributions, which are transfers from the general fund of the Treasury, and premium income.

General fund transfers finance about three-quarters of SMI costs and are central to the automatic financial balance of the fund's two accounts. These transfers represent a large and growing requirement for the Federal budget. SMI government contributions were 1.7 percent of GDP in 2024 and are projected to increase to approximately 3.5 percent in 2099. (SMI government contributions in 2099 would be 4.3 percent under the illustrative alternative scenario.)

Conclusion

Total Medicare expenditures were $1,122.1 billion in 2024. Based on the intermediate set of assumptions, the Trustees project that expenditures will increase at a faster pace in future years than either aggregate workers' earnings or the economy overall. Spending as a percentage of GDP is projected to increase from 3.8 percent in 2024 to 6.7 percent by 2099. Under the relatively higher price increases for physicians and other health services assumed for the illustrative alternative projection, Medicare spending would represent roughly 8.8 percent of GDP in 2099. Growth under either of these scenarios would substantially increase the strain on the nation's workers, the economy, Medicare beneficiaries, and the Federal budget.

The Trustees project that HI tax income and other non-interest income will fall short of HI incurred expenditures beginning in 2027. The HI trust fund does not meet either the Trustees' test of short-range financial adequacy or their test of long-range close actuarial balance.

The Part B and Part D accounts in the SMI trust fund are expected to be adequately financed because income from premiums and government contributions are reset each year to cover expected costs. However, this financing would have to increase faster than the economy to cover expected expenditure growth.

The projections in this report show that change is needed to address Medicare's financial challenges. If elements of current law are not adhered to, even more substantial changes could be needed, as shown in the illustrative alternative scenario. The sooner solutions are enacted, the more flexible and gradual they can be. Introducing reforms early would

give affected individuals and organizations— including health care providers, beneficiaries, and taxpayers—more time to adjust their expectations and behavior. The Trustees recommend that Congress and the executive branch work closely together to quickly address these challenges.

Further Reading

Centers For Medicare and Medicaid (CMS), 2025 Annual Report of The Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds
2025 Medicare Trustees Report (cms.gov)

Social Security Administration, How To Apply Online for Medicare Only;
https://www.ssa.gov/pubs/EN-05-10531.pdf

Medicare and You, 2025
https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf

Chapter 10
Review Questions

1. Medicare was established in 1965 under what Title of the Social Security Act?

( ) A. Title X
( ) B. Title XVIII
( ) C. Title XXIII
( ) D. Title XXX

2. Which of the following trust funds is used to pay expenses for Part A?

( ) A. The Hospital Insurance (HI) Trust Fund
( ) B. The Supplementary Medical Insurance (SMI) Trust Fund
( ) C. The Disability Insurance (DI) Trust Fund
( ) D. The Old-age Survivor Insurance (OASI) Trust Fund

3. True or False? The Department of Health and Human Services (DHHS) has the overall responsibility for the administration of the Medicare program.

( ) A. True
( ) B. False

4. According to the 2025 Medicare Trustees Report, in what year is the Hospital Insurance (HI) Trust Fund for Medicare Part A projected to be depleted?

( ) A. 2034
( ) B. 2033
( ) C. 2028
( ) D. 2027

5. According to the 2025 Medicare Trustees Report, what is the projected average annual growth rate of Medicare Part B costs over the next five years?

( ) A. 43.7%
( ) B. 1.5%
( ) C. 8.8%
( ) D. 25.5%

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CHAPTER 11

MEDICARE PART A

Overview

Medicare Part A is referred to as Hospital Insurance (HI) and covers most of the cost of inpatient care in hospitals (such as critical access hospitals, inpatient rehabilitation facilities, and long-term care hospitals) and several other services.

This chapter will review Medicare Part A, its eligibility requirements; services provided; how it is financed; its various out-of-pocket costs (such as premiums, deductibles, and copays); and the enrollment periods.

Learning Objectives

Upon completion of this chapter, you will be able to:

- Determine eligibility for Part A.
- Explain the financing of Part A.
- Outline Part A covered services and costs; and
- Observe Part A enrollment periods and late fees.

Who Is Eligible for Part A (HI)

All persons aged 65 and over who are entitled to monthly Social Security benefits (or would be entitled to benefits except that an application for benefits has not been filed), or monthly benefits under Railroad Retirement programs (whether retired or not), are eligible for benefits.

Persons aged 65 and over can receive Medicare benefits even if they continue to work. Enrollment in the program while working will not affect the amount of any future Social Security benefits.

A dependent or survivor of a person entitled to HI benefits, or a dependent of a person under age 65 who is entitled to retirement or disability benefits, is also eligible for HI (Part A) benefits if the dependent or survivor is at least 65 years old. For example, a woman aged 65 or over who is entitled to a spousal or widow's Social Security benefit is eligible for benefits under Hospital Insurance.

A Social Security disability beneficiary is covered under Medicare after entitlement to disability benefits for 24 months or more. Those covered include disabled workers at any age, disabled widows and widowers aged 50 or over, beneficiaries aged 18 or older who receive benefits because of disability beginning before age 22 and disabled qualified railroad retirement annuitants. Medicare coverage is automatic. No application is required.

A person who becomes re-entitled to disability benefits within five years after the end of a previous period of entitlement (within seven years in the case of disabled widows or widowers and disabled children) is automatically eligible for Medicare coverage without the need to wait another 24 months. However, if the previous period of disability ends on or after March 1, 1988, and the current impairment is the same as or directly related to the impairment in the previous period of disability, they are covered without again needing to meet the 24-month waiting period requirement.

Coverage will continue for 24 months after an individual is no longer entitled to receive disability payments because they have returned to work, provided they were considered disabled on or after December 10, 1980, and the disabling condition continues.

Special Eligibility Rules for Persons with End-Stage Renal Disease

Part A coverage is also provided to insured workers (and their dependents) with end-stage renal diseases (ESRD) who require renal dialysis or a kidney transplant even if they are working. Coverage can begin the first day of the third month after the month dialysis treatments begin.

Special Rules for Government Employees

Federal employees who were not covered under Social Security (temporary workers have been covered since 1951) began paying the Hospital Insurance (HI) portion of Social Security tax in 1983. Those covered under Social Security, such as virtually all hired after 1983, pay the HI tax and the Social Security Old-Age, Survivors, and Disability Insurance (OASDI) tax. A transitional provision provides credit for retroactive quarters of coverage for federal employees employed before 1983 and on January 1, 1983.

State and local government employees hired after March 31, 1986, are covered under Medicare coverage and tax provisions. A person performing substantial and regular service for a state or local government before April 1, 1986, is covered provided they were a bona fide employee on March 31, 1986, and the employment relationship was not entered into to meet the requirements for exemption from coverage.

State or local government employees whose employment is terminated after March 31, 1986, are covered under Medicare if they are later rehired.

Beginning after June 30, 1991, state and local government workers who are not covered by a retirement system in conjunction with their employment and are not already subject to the HI tax are also automatically covered and must pay the tax. A retirement system is defined as a pension, annuity, retirement, or similar fund or system established by a state or by a political subdivision of a state.

Also, if the beneficiary or their spouse has a sufficient period of Medicare-only coverage in federal, state, or local government employment, they are eligible beginning at age 65. Similarly, if they have been entitled to Social Security or Railroad Retirement disability benefits for at least 24 months, and government employees with Medicare-only coverage who have been disabled for more than 29 months are entitled to Part A benefits. The waiting period is waived for persons with Lou Gehrig's Disease.

Part A Premium

Part A is generally provided automatically and free of premiums to the beneficiary if they are age 65 or over and are eligible for Social Security (40 quarters) or Railroad Retirement benefits, whether they have claimed these monthly cash benefits or not.

People older than 65 who are not eligible for free Medicare Part A coverage (neither they nor their spouse has paid Medicare taxes for a minimum of 10 years–40 quarters) can nevertheless enroll in it and pay a monthly premium. Individuals who had at least 30 quarters of coverage or were married to someone with at least 30 quarters of coverage may buy into Part A at a reduced monthly premium rate, which will be $285 in 2025, a $7 increase from $278 in 2024. Certain uninsured aged individuals who have fewer than 30 quarters of coverage, and certain individuals with disabilities who have exhausted other entitlements, will pay the full premium which will be $518 a month in 2025, a $13 increase from $503 in 2024. In most cases, if an individual chooses to buy Part A, they must also have Part B and pay monthly premiums for both.

CMS estimates that approximately 729,000 enrollees will voluntarily enroll in Medicare Part A by paying the full premium and that over 90 percent of these individuals will have their Part A premium paid for by states, since they are entitled to Part A and enrolled in the QMB program eligibility group.

Part A Financing

Like the Social Security system, Part A (HI) portion of Medicare was designed to be self-supporting and financed through dedicated income sources rather than relying on general tax revenues. The primary source of income credited to the HI Trust Fund is payroll taxes (FICA tax) paid by employees and employers: each pays a tax of 1.45% on earnings. The self-employed (SECA tax) pay 2.9%. Unlike Social Security, there is no upper limit on earnings subject to the tax.

ACA imposes an additional tax of 0.9% on high-income workers with wages over $200,000 for single filers and $250,000 for joint filers (not indexed with inflation). ACA also imposes an additional surtax of 3.8% on unearned income (IRC § 1411). However, this tax is not credited to the HI Trust Fund. (For this additional surtax, investment income includes taxable interest; capital gains; dividends; royalties; annuities; and income from business conducted as sole proprietorships, partnerships, or S corporations in which the owner is not an active participant. The Medicare tax will not apply to pensions, distributions from 401(k)s, IRAs, etc.) Revenue collected under this surtax (IRC § 1411) will be paid to the Treasury's general account.

> ***Example 1:*** Single individual filers whose income is $225,000, will pay a 1.45% Medicare tax on the first $200,000, then 2.35% (1.45% plus 0.9%) on the next $25,000. Their employer is required to withhold an extra 0.9% once their wages pass the $200,000 threshold for individuals.
>
> ***Example 2:*** Married couples who both earned income of $150,000 will have their employer withhold 1.45% for Medicare tax because neither of them exceeds the $200,000 individual threshold. If they file a joint tax return, their combined earned income of $300,000 is $50,000 above the married filing jointly threshold. This means they will have underpaid their Medicare tax by $450 (0.9% of $50,000) and will owe the additional amount when they file their taxes.

Note: There is a special federal (generally following through to state) income tax deduction of 50% of the OASDI/HI self-employment (SECA) tax. This income tax deduction, which is available regardless of whether the beneficiary itemizes deductions, is designed to treat the self-employed in much the same manner as employees and employers are treated for Social Security and income tax purposes. However, the additional Medicare payroll surtax will not be deductible by the self-employed individual.

State Medicare Savings Program

If a beneficiary has limited income and resources, their state may help them pay for Part A (and/or Part B). There are four State Medicare Savings Programs. They are:

- Qualified Medicare Beneficiary (QMB);
- Specified Low-Income Medicare Beneficiary (SLMB);
- Qualifying Individual (QI); and
- Qualified Disabled & Working Individuals (QDWI).

Each program has a different income and resource liability limit. Even if individuals do not qualify for Medicaid, they may qualify for one of these programs to help cover their Medicare costs. If a beneficiary qualifies for a QMB, SLMB, or QI program, they automatically qualify to get Extra Help paying for Medicare prescription drug coverage.

HI Trust Fund

Table 11.1 presents a statement of the revenue and expenditures of the HI Trust Fund in the calendar year 2024 and its assets at the beginning and end of the calendar year. The total assets of the trust fund amounted to $208.8 billion on December 31, 2023. During calendar year (CY) 2024, total revenue amounted to $451.2 billion, and total expenditures were $422.5 billion. Total assets increased by $28.7 billion during the year to $237.5 billion on December 31, 20224.

Table 11.1
Statement of Operations of the HI Trust Fund
During Calendar Year 2024
(In thousands)

	HI or Part A
Assets at end of 2023 (billions)	$208.8
Total Income	$451.2
Payroll taxes	$396.4
Interest	$7.2
Taxation of benefits	$39.8
Premiums	$5.0
General revenue	$1.2
Transfer from States	-
Other	$1.6
Total expenditures	$422.5
Benefits	$416.3
Hospital	$144.4
Skilled nursing facility	$28.5
Home health care	$5.9
Physician fee schedule services	-
Private health plans (Part C)	$192.5
Prescription drugs	-
Other	$44.9
Administrative expenses	$6.2
Net change in assets	$28.7
Assets at end of 2024	$237.5
Enrolled (millions)	
Aged	59.9
Disabled	7.3
Total	67.2
Average benefit per enrollee	$6,193

Source: Board of Trustees, 2025. Table II. B1.
2025 Medicare Trustees Report (cms.gov)

Revenues

The trust fund's primary source of income consists of amounts appropriated to it, under permanent authority, on the basis of taxes paid by workers, their employers, and individuals with self-employment earnings, in work covered by HI. Included in HI are workers covered under the OASDI program, those covered under the Railroad Retirement program, and certain Federal, State, and local employees not otherwise covered under the OASDI program.

HI taxes are payable without limit on a covered individual's total wages and self-employment earnings. For calendar years prior to 1994, taxes were computed on a person's annual earnings up to a specified maximum annual amount called the maximum tax base.

Total HI payroll tax income in calendar year 2024 amounted to $396.4 billion—an increase of 8.0 percent over the amount of $367.2 billion for the preceding 12-month period. This increase occurred primarily because both the number of covered workers and average wages were higher.

Up to 85 percent of an individual's or couple's OASDI benefits may be subject to Federal income taxation if their income exceeds certain thresholds. The income tax revenue attributable to the first 50 percent of OASDI benefits is allocated to the OASI and DI trust funds. The revenue associated with the amount between 50 and 85 percent of benefits is allocated to the HI trust fund. Income from the taxation of OASDI benefits amounted to $39.8 billion in calendar year 2024.

Another substantial source of trust fund income is interest credited from investments in government securities held by the fund. In the calendar year 2024, the fund received $7.2 billion in such interest.

Section 1818 of the Social Security Act provides that certain persons not otherwise eligible for HI protection may obtain coverage by enrolling in HI and paying a monthly premium. In 2024, premiums collected from such voluntary participants (or paid on their behalf by Medicaid) amounted to about $4.8 billion.

The Railroad Retirement Act provides for a system of coordination and financial interchange between the Railroad Retirement program and the HI trust fund. This financial interchange requires a transfer that would place the HI trust fund in the same position in which it would have been if the Social Security Act had always covered railroad employment. In accordance with these provisions, a transfer of $645 million in principal and about $14 million in interest from the Railroad Retirement program's Social Security Equivalent Benefit Account to the HI trust fund balanced the two systems as of September 30, 2023. The trust fund received this transfer, together with interest to the date of transfer totaling about $12 million, in June 2024.

Legislation in 1982 added transitional entitlement for those Federal employees who retire before having had a chance to earn sufficient quarters of Medicare-qualified Federal

employment. The general fund of the Treasury provides reimbursement for the costs of this coverage, including administrative expenses. In the calendar year 2024, such reimbursement amounted to $44 million for estimated benefit payments for these beneficiaries.

Legislation in 1996 established a health care fraud and abuse control account within the HI trust fund. Monies derived from the fraud and abuse control program are transferred from the general fund of the Treasury to the HI trust fund. During the calendar year 2024, the trust fund received about $1,221 million from this program.

Expenses

The HI trust fund pays expenditures for HI benefit payments and administrative expenses. All HI administrative expenses incurred by the Department of Health and Human Services, the Social Security Administration, the Department of the Treasury (including the Internal Revenue Service), and the Department of Justice in administering HI are charged to the trust fund. Such administrative duties include payment of benefits, the collection of taxes, fraud and abuse control activities, and experiments and demonstration projects designed to determine various methods of increasing efficiency and economy in providing health care services, while maintaining the quality of such services, under HI and SMI.

In addition, Congress has authorized expenditures from the trust funds for construction, rental and lease, or purchase contracts of office buildings and related facilities for use in connection with the administration of HI. Although trust fund expenditures include these costs, the statement of trust fund assets presented in this report does not carry the net worth of facilities and other fixed capital assets because the proceeds of sales of such assets revert to the General Services Administration. Since the value of fixed capital assets does not represent funds available for benefit or administrative expenditures, the Trustees do not consider it in assessing the actuarial status of the funds.

Of the $422.5 billion in total HI expenditures, $416.3 billion represented net benefits paid from the trust fund for health services. Net benefit payments increased 4.7 percent in calendar year 2024 over the corresponding amount of $397.5 billion paid during the preceding calendar year. These payments reflect the change in the number of beneficiaries, the price of health services, and the volume and intensity of services.

The remaining $6.2 billion in expenditures was for net HI administrative expenses, after adjustments to the preliminary allocation of administrative costs among the Social Security and Medicare trust funds and the general fund of the Treasury. The expenditure amount of $6.2 billion also included $2.9 billion for the health care fraud and abuse control program.

Part A Covered Services

The following health care services are covered under Part A:

- *Blood.* In most cases, the hospital gets blood from a blood bank at no charge, and the beneficiary will not have to pay for it or replace it. If the hospital has to buy blood for the beneficiary, they must either pay the hospital costs for the first 3 units of blood they get in a calendar year or have the blood donated by them or someone else.
- *Hospital Stays (Inpatient).* Includes costs of a semi-private room, meals, regular nursing services, operating and recovery rooms, intensive care, inpatient prescription drugs, laboratory tests, X-rays, psychiatric hospitals, inpatient rehabilitation, and long-term care hospitalization when medically necessary, as well as all other medically necessary services and supplies provided in the hospital. An initial deductible payment is required if they are admitted to a hospital, plus copayments for all hospital days following day 60 within a benefit period (described later).
- *Skilled nursing facility (SNF).* Skilled nursing facility care is covered by Part A only if it follows within 30 days (generally) of hospitalization of 3 days or more and is certified as medically necessary (patient receives medical care 7 days per week, or rehabilitation care 5 days per week). Covered services are like those for inpatient hospitals but also include rehabilitation services and appliances. The number of skilled nursing facility (SNF) days provided under Part A is limited to 100 days per benefit period (described later), with a copayment required for days 21-100. Part A does not cover nursing facility care if the beneficiary does not require skilled nursing or skilled rehabilitation services.
- *Home Health Services.* Limited to medically necessary part-time or intermittent skilled nursing care, physical therapy, speech-language pathology, or a continuing need for occupational therapy. The term "part-time or intermittent" means skilled nursing and home health aide services furnished by any number of days per week as long as they are provided less than 8 combined hours each day and 28 or fewer hours per week (or subject to review on a case-by-case basis as to the need for care less than 8 hours each and 35 or fewer hours per week. A doctor must order care for the beneficiary, and a Medicare certified-home health agency (HHA) must provide it. Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment, and medical supplies for use at home. The beneficiary must be homebound, which means that leaving home is a major effort. Home health care under Part A (and Part B) has no copayment and no deductible; and
- *Hospice Care.* Hospice care is a service provided to terminally ill people with life expectancies of 6 months or less who elect to forgo the standard Medicare benefits to treat their illness and receive only hospice care. Such care includes drugs for pain relief and symptom management, medical, nursing, and social services, and other covered services, as well as services Medicare usually doesn't cover, such as grief counseling. A Medicare-approved hospice usually gives hospice care in their home or another facility like a nursing home. Hospice care doesn't include room and board unless the hospice medical team determines that

your client needs short-term inpatient stays for pain and symptom management that can't be addressed in the home. These stays must be in a Medicare-approved facility, such as a hospice facility, hospital, or skilled nursing facility. Medicare also covers inpatient *respite care*, which is care they will get in a Medicare-approved facility so that their usual caregiver can rest. The beneficiary can stay up to 5 days each time they get respite care. Medicare will pay for covered services for health problems that aren't related to their terminal illness. They can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies that they are terminally ill. The beneficiary pays no deductible for the hospice program. Still, they will pay a small coinsurance amount for drugs and inpatient respite care.

An important Part A component is the benefit period, which starts when they first enter a hospital and ends when there has been a break of at least 60 consecutive days since an inpatient hospital or skilled nursing care was provided. There is no limit to the number of benefit periods covered by Part A during their lifetime; however, inpatient hospital care is normally limited to 90 days during a benefit period, and copayment requirements (detailed later) apply for days 61-90. If the 90 days of inpatient hospital care available in a benefit period is exhausted, the beneficiary can elect to use days of Medicare coverage from a non-renewable "lifetime reserve" of up to 60 (total) additional days of inpatient hospital care. Copayments are also required for such additional days.

Medicare Part A does not pay for:

- Services of physicians and surgeons, including the services of pathologists, radiologists, anesthesiologists, and physicians. (Hospital Insurance does not pay for the services of a physician, resident physician, or intern–except those provided by an intern or resident in training under an approved teaching program).
- Services of a private duty nurse or attendant, unless the condition requires such services, and the nurse or attendant is a bona fide employee of the hospital.
- Personal convenience items supplied at the beneficiary's request, such as television rental, radio rental, or telephone.
- The first three pints of whole blood (or packed red blood cells) received in a calendar year; and
- Supplies, appliances, and equipment for use outside the hospital, unless continued use is required (e.g., a pacemaker).

Medicare beneficiaries have the right to receive the care necessary for the proper diagnosis.

Costs for Part A Services

Under Part A Hospital Insurance, except for the deductible amount that the beneficiary must pay, Medicare helps pay for inpatient hospital services for up to 90 days in each "benefit period."

In 2025, the beneficiary pays:

- $1,676 (an increase of $44 from $1,632 in 2024) deductible and no coinsurance for days 1-60 in each benefit period.
- $419 (an increase of $11 from $408 in 2024) per day for days 61-90 in each benefit period.
- $838 (an increase of $22 from $816,00 in 2024) per "lifetime reserve day" after day 90 in each benefit period (up to 60 days over the beneficiary's lifetime).
- All costs for each day after the lifetime reserve days.
- Inpatient mental health care in a psychiatric hospital is limited to 190 days in a lifetime: and
- Skilled nursing facility stays (SNF discussed below).

Medicare pays for hospital care if the beneficiary meets the following four conditions:

- A doctor prescribes inpatient hospital care for treatment of illness or injury.
- They require the kind of care that can only be provided in a hospital.
- The hospital is participating in Medicare; and
- The Utilization Review Committee of the hospital, a Quality Improvement Organization (QIO), or an intermediary does not disapprove of the stay.

In 2025, for skilled nursing home (SNF), the beneficiary will be responsible for paying the following out-of-pocket costs:

- $0 for the first 20 days of each benefit period.
- $209.50 (up $5.90 from $204 in 2024) per day for days 21-100 each benefit period; and
- All costs for each day after day 100 in a benefit period.

Part A Enrollment Periods

If the beneficiary wishes to enroll in Part A (Hospital Insurance), here are the following periods during which they must sign up:

- *Automatic Enrollment Period (AEP)*. If the beneficiary is receiving Social Security benefits prior to age 65, they should be automatically enrolled. Coverage begins the first day of their birth month if they are 65 years old, or the first day of the 25th month of recurring benefits:
    - They will receive a Medicare card in the mail from Social Security three months before their 65th birthday notifying them of enrollment in Medicare Part A (and Part B). If they do not want Part B, they must return the card appropriately marked, and they will be enrolled for Part A coverage only; or
    - If no card is received, the beneficiary should contact their nearest Social Security Administration office prior to their 65th birthday.

- *Initial Enrollment Period (IEP)*. The initial enrollment period (IEP) applies if the beneficiary is just turning 65 and has not received Social Security benefits. This is a seven-month period. The seven-month initial enrollment period begins three months prior to their birth month and ends three months following their birth month. The month of enrollment determines when Medicare coverage becomes effective:
    - If the beneficiary enrolls during the three months prior to reaching their 65th birthday, they are covered beginning on the first day they turn age 65 (fourth month or month of eligibility);
    - If the beneficiary is enrolling during the month they turn age 65 (fourth month), or one to to three months after they turn age 65, coverage begins the first day of the month after they sign up.
- *General Enrollment Period (GEP)*. The general enrollment period (GEP) is from January 1 through March 31 of each year. The GEP allows beneficiaries who didn't sign-up for Part A when they were first eligible to sign up for Part A. The beneficiaries coverage will begin the first day of the month after the beneficiary signed up They may also have to pay a higher premium for late enrollment (discussed below):
- *Special Enrollment Period (SEP)*. The special enrollment period will apply if the beneficiary:
    - Continues to work past age 65 and are covered under an employer group health plan (EGHP);
    - They must notify Social Security of their intent to remain covered by the employer group health plan (EGHP);
    - These individuals may enroll at any time after age 65, but they must enroll no later than eight (8) months after the month of their retirement or of the person who is working.
    - They also have the option of enrolling anytime during the year while they are still working if they decide they want Medicare coverage or if their EGHP is discontinued.
    - If they enroll in any other month, coverage begins the month following.
    - If they are eligible for special enrollment, they are not penalized with a 10 percent surcharge provided they enroll no later than eight months after the month of retirement; and
    - This Special Enrollment Period doesn't apply to people with End-Stage Renal Disease (ESRD).

Part A Late Enrollment Fee

If the beneficiary is not eligible for premium-free Part A and did not purchase when first eligible (at age 65), their monthly premium may go up 10%. If the beneficiary did not enroll during this period but decided to enroll later, they will be required to pay a late enrollment penalty. The beneficiary's monthly premium will increase by 10 percent for the number of years, equaling twice the time they waited before enrolling in Part A after their eligibility started.

***For Example**:* If Bob were ineligible for premium-free Part A and did not purchase for 2 years, he would have to pay the higher premium for 4 years.

Once again, a beneficiary can avoid this late enrollment fee if they sign up during either the Initial Enrollment Period or the Special Enrollment Period discussed above.

Further Reading

CMS.gov, "*2025 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*;"
2025 Medicare Trustees Report (cms.gov)

CMS.gov, "*What Medicare Part A Covers*," https://www.medicare.gov/what-medicare-covers/what-part-a-covers

CMS.gov, "*Medicare and You 2025 Handbook*,"
https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf

CY 2024 Inpatient Hospital Deductible and Hospital Extended Care Services Coinsurance Amounts
2023-22850.pdf (federalregister.gov)

Chapter 11
Review Questions

1. Medicare Part A is referred to as:

( ) A. Hospital Insurance (HI)
( ) B. Medical Insurance (MI)
( ) C. Supplemental Medical Insurance (SMI)
( ) D. Physician Services (PI)

2. What is the Part A (HI) FICA tax rate for an employee?

( ) A. 2.90%
( ) B. 1.45%
( ) C. 0.90%
( ) D. 3.80%

3. A benefit period ends when the patient has been out of a hospital or other facility primarily providing skilled nursing or rehabilitative services for how many days in a row (including the day of discharge).

( ) A. 20 days
( ) B. 30 days
( ) C. 60 days
( ) D. 90 days

4. For 2025, an individual older than 65 who has only 30-39 quarters of coverage can purchase Part A with a monthly premium of what amount?

( ) A. $285
( ) B. $204
( ) C. $818
( ) D. $505

5. The initial enrollment period for Part A begins how many months prior to the beneficiary's birth month?

( ) A. 3
( ) B. 5
( ) C. 7
( ) D. 12

CHAPTER 12

MEDICARE PART B

Overview

Medicare Part B is referred to as Supplementary Medical Insurance (SMI) and covers doctor services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as physical and occupational therapists and some home health care services.

This chapter will review Medicare Part B, its eligibility requirements; the type of services covered and not covered; the financing; the various out-of-pocket costs (such as premiums, deductibles, and copays); and the various enrollment periods.

Learning Objectives

Upon completion of this chapter, you will be able to:

- Determine eligibility for Medicare Part B.
- Explain the financing of Medicare Part B.
- Outline the Part B beneficiary out-of-pocket costs: standard premiums; IRMAA premium; deductible; and copayments and coinsurance amounts.
- Explain how the Medicare Part B premium and deductible are changing for 2025.
- Relate the provisions of the Bipartisan Budget Act of 2015 and the implications for beneficiary premiums and deductibles in 2025 and future years.
- List the various types of services covered and not covered by Medicare Part B; and
- Observe the Part B enrollment periods and late fees.

Let's begin with a review of the eligibility rules for Medicare Part B.

Part B Eligibility

All persons entitled to premium-free Hospital Insurance (Part A) or premium Hospital Insurance (Part A) or the working disabled under Medicare may enroll in Medicare Part B. Social Security and Railroad Retirement beneficiaries, age 65 or over, are therefore automatically eligible.

Any other person aged 65 or over may enroll provided that they are a resident of the United States and is either:

- A citizen of the United States; or
- An alien lawfully admitted for permanent residence who has resided in this country five consecutive years before applying for Medicare.

Disabled beneficiaries (workers under age 65, widow(er)s, aged 50-64, and children aged 18 or over and disabled before age 22) who have been on the benefit roll as a disability beneficiary for at least two years are covered in the same manner as persons aged 65 or over (this includes disabled Railroad Retirement beneficiaries). Disability cases are also covered for 48 months after cash benefits cease for a worker engaging in substantial gainful employment but has not medically recovered. (Disability benefits are, under such circumstances, paid for the first nine months of the trial-work period and then for an additional three months). After 48 months and during continued disability, voluntary coverage is available in the same manner as non-insured persons aged 65 or over.

A person can continue to buy Medicare Hospital Insurance (Part A) only, or both Hospital Insurance and Supplement Medical Insurance (Part B) if they remain disabled. Such a person may enroll during their initial enrollment period, which begins with the month they are notified they are no longer eligible for premium-free Hospital Insurance and continue for seven full months after that month. If a person does not enroll during this initial enrollment period, the person may enroll in a subsequent general enrollment period (January 1 through March 31 of each year) or during a special enrollment period.

Also covered are people with end-stage renal disease who require dialysis or a kidney transplant and are eligible for Hospital Insurance (Part A).

Like Medicare Part A, Part B eligibility and enrollments are managed by the Social Security Administration.

Part B Financing

Financing of Part B (the SMI Trust Fund) differs fundamentally from the HI Trust Fund regarding the nature of its financing. The nature of financing for Part B is primarily by contributions from the general fund of the U.S. Treasury (and to a much lesser degree) monthly premiums paid by the beneficiary (discussed below)

For Part B, the contributions from the U.S. Treasury's general fund are the largest source of income since the monthly premium is generally set at a level that covers only 25 percent of the average expenditures for aged beneficiaries.

The total assets of the account amounted to $172.2 billion on December 31, 2023. During calendar year 2024, total revenue amounted to $532.9 billion, and total expenditures were $553.4 billion. Total assets were $151.7 billion as of December 31, 2024. The asset level decreased during 2024 by approximately $20.5 billion (see Table 12.1).

Table 12.1
Part B Medicare Data for CY 2024

	Part B
Assets at end of 2023 (billions)	$172.2
Total Income	$532.9
Payroll taxes	-
Interest	$3.5
Taxation of benefits	-
Premiums	$140.1
General revenue	$386.0
Transfer from States	-
Other	$3.2
Total expenditures	$553.4
Benefits	$547.8
Hospital	$80.5
Skilled nursing facility	-
Home health care	$10.0
Physician fee schedule services	$71.4
Private health plans (Part C)	$301.6
Prescription drugs	-
Other	$84.3
Administrative expenses	$5.6
Net change in assets	-$20.5
Assets at end of 2024	$151.7
Enrolled (millions)	
Aged	55.2
Disabled	6.8
Total	62.0
Average benefit per enrollee	$8,831

Source: Board of Trustees, 2025. Table III C1.
2025 Medicare Trustees Report (cms.gov)

Revenues

The major sources of revenue for the Part B account are:

- Contributions of the Federal Government that the law authorizes to be appropriated and transferred from the general fund of the Treasury and
- Premiums paid by (or on behalf of) eligible people who voluntarily enroll.

Of the total Part B revenue in calendar year 2024, $139.8 billion represented premium payments by (or on behalf of) enrollees—an increase of 6.6 percent over the amount of $131.2 billion for the preceding year.

Government contributions matched the premiums paid for fiscal years 1967 through 1973 dollar for dollar. Beginning July 1973, disabled persons who are under age 65 and who have met certain other conditions became eligible to enroll in Medicare, and the calculation of the premium-matching government contributions was changed. The amount of government contributions corresponding to premiums paid is determined by applying a matching rate to the amount of premiums received. By law, a matching rate is determined for each of two groups of Part B enrollees—one for those aged 65 and older and one for the disabled. The matching rate is equal to twice the monthly actuarial rate applicable to the group of enrollees, minus the standard monthly premium rate, divided by the standard monthly premium rate.

In the calendar year 2024, contributions received from the general fund of the Treasury amounted to $386.0 billion, which accounted for 772.4 percent of total revenue. The Bipartisan Budget Act of 2015 and the Continuing Appropriations Act, 2021 and Other Extensions Act require that payments be made from the Part B account of the SMI trust fund to the general fund of the Treasury, and these amounts totaled $1.7 billion in 2024. Transfers amounting to $5.2 billion were made from the Part B account to the general fund to adjust for certain transfers made for exempted amounts. In accordance with the Continuing Appropriations Act, 2021 and Other Extensions Act, $36 million of the government contributions represent a transfer from the Part B account to the general fund to partially repay the outstanding balance of the Accelerated and Advance Payments (AAP) Program. The balance of the general fund transfers consisted almost entirely of premium-matching contributions.

Another source of Part B revenue is interest received on investments held by the Part B account. A description of the investment procedures of the Part B account appears later in this section. In the calendar year 2024, $3.5 billion of revenue was from interest on the investments of the account. One more source of Part B revenue is the annual fees assessed on manufacturers and importers of brand-name prescription drugs, which amounted to $2.8 billion in 2024.

Expenses

The account pays expenditures for Part B benefit payments and administrative expenses. All expenses incurred by the Department of Health and Human Services, the Social Security Administration, and the Department of the Treasury in administering Part B are charged to the account. Such administrative duties include payment of benefits, fraud and abuse control activities, and experiments and demonstration projects designed to determine various methods of increasing efficiency and economy in providing health care services while maintaining the quality of these services.

In addition, Congress has authorized expenditures from the trust funds for construction, rental and lease, or purchase contracts of office buildings and related facilities for use in connection with the administration of Part B. The account expenditure includes such costs. The net worth of facilities and other fixed capital assets, however, does not appear in the statement of Part B assets presented in this report, since the value of fixed capital

assets does not represent funds available for benefit or administrative expenditures and is not, therefore, pertinent in assessing the actuarial status of the funds.

Of total Part B expenditures, $547.8 billion represented net benefits paid from the account for health services. Net benefits increased 10.1 percent compared with the corresponding amount of $497.4 billion paid during the preceding calendar year. The change in net benefits paid reflects the AAP program repayments and the net change in both the number of beneficiaries and the price, volume, and intensity of services. The remaining $5.6 billion of expenditures was for administrative expenses and represented 1.1 percent of total Part B expenditures in 2024. Administrative expenses are shown on a net basis, after adjustments to the preliminary allocation of such costs among the Social Security and Medicare trust funds and the general fund of the Treasury.

Future of Part B SMI Trust Fund

The Trustees project that the Part B account of the SMI trust fund will remain in financial balance for all future years because beneficiary premiums and general fund transfers are assumed to be set at a level to meet expected costs each year.

Part B Standard Monthly Premium

Over the 50-year history of the Medicare program, Part B premiums have changed nearly every year by varying percentages, ranging from a reduction of 13 percent to an increase of 39 percent. In general, premiums have increased from one year to the next, reflecting the Part B program spending growth, except for 2023. The 2025 standard monthly premium will be $185, an increase of $10.30 from $174.70 in 2024 (see Table 12.2).

Table 12.2
Part B Historical Monthly Premium (1970 – 2025)

Calendar Year	Standard Monthly Premium
1970	$4.00
1980	$8.70
1990	$28.60
2000	$45.50
2005	$78.20
2010	$110.50
2015	$104.90
2020	$144.60
2021	$148.50
2022	$170.10
2023	$164.90
2024	$174.70
2025	$185.00

Source: SSA, SMI Cost Charing page 198 Table V-E.2
Source: 2024 Medicare Parts A & B Premiums and Deductibles | CMS

The Part B standard monthly premium amount is derived from a monthly actuarial rate determined by the Secretary of the Department of Health and Human Services (HHS) in September of each year for the succeeding year, such that, in the aggregate, premiums will cover 25 percent of Part B (and Part D) program spending and provide for adequate reserves in the Supplementary Medical Insurance (SMI) Trust Fund, with general revenues covering the remaining 75 percent of program spending.

According to CMS, the standard monthly premium for Medicare Part B enrollees will be $185 per month, which is equal to 50 percent of the monthly actuarial rate for age enrollees of $487.80 (or approximately 25 percent of the expected average total cost of Part B coverage for aged enrollees) plus the $3.00 repayment amount required under current law. (The 2025 premium is 7 percent or $10.30 higher than the 2024 standard premium rate of $174.10, which included the $3.00 repayment amount.) CMS has estimated that this premium increase will affect approximately 56 million Part B enrollees in 2025.

However, a statutory "*hold harmless*" provision may apply to a small number of enrollees. Specifically, if a beneficiary collects Social Security benefits and their Medicare premium is deducted from those benefits each month (this is the case for most people with Medicare), the "*hold-harmless*" rule may apply. The hold-harmless rule protects a beneficiary from having their previous year's Social Security benefit level reduced by an increase in the Part B premiums so long as the beneficiary:

- Enrollee was entitled to Social Security benefits for November and December of the previous year (2024);
- The Medicare Part B premium will be or was deducted from enrollee's Social Security benefits in November 2024 through January 2025.
- Enrollee does not already pay higher Part B premiums because of Income Related Monthly Adjustment Amount (IRMAA) eligibility; and
- Enrollees do not receive a Cost-of-Living Adjustment (COLA) large enough to cover the increased premium.

If the COLA is not large enough to cover the full amount of the increased premium, the enrollee will be held harmless, and their premium will not increase. Instead, their premium will be the same as the previous year.

Note: In 2025, the COLA premium increase is 3.2%, an average of $490 per month vs. an increase in the Part B premium of $10.30 per month. The hold-harmless protection will not be in place.

If the enrollee qualifies for the hold-harmless provision but pays a Part B late enrollment penalty, the penalty will not be waived, and it may increase. The penalty will be calculated based on the new, higher premium–even if the enrollee is not paying that higher amount.

Medicare Part B enrollees not subject to the "*hold harmless*" provision include beneficiaries who do not receive Social Security benefits, those who enroll in Part B for the first time in 2025, those who are directly billed for their Part B premium, those who are dually eligible for Medicaid and have their premium paid by state Medicaid agencies, and those who pay an income-related premium. These groups represent approximately 30 percent of the total Part B beneficiaries.

Income-Related Monthly Adjusted Amount (IRMAA)

The *Medicare Prescription Drug, Improvement and Modernization Act of 2003*, referred to as the *Medicare Modernization Act* (MMA, P.L. 108-173), established an "*income-related monthly adjusted amount"* (IRMAA) Part B premium that took effect in 2007, requiring high-income Medicare beneficiaries to pay a greater share of average Part B costs, ranging from 35 percent to 85 percent, depending on their income. The Internal Revenue Service (IRS) supplies the tax filing status, adjusted gross income, and tax-exempt interest income to the SSA to determine if the beneficiary has an IRMAA. The SSA will add Adjusted Gross Income (AGI) together with tax-exempt interest income to get an amount called the Modified Adjusted Gross Income (MAGI) –as obtained by the SSA in any particular year–as determined from the beneficiary's federal income tax return two years prior.

The income brackets used to determine Medicare Part premium surcharges for high-income retirees will be indexed to inflation, except for the top-level income thresholds of $500,000 for individuals and $750,000 married couples filing jointly that were added in 2019. Those top tiers will be indexed to inflation starting in 2028. The IRMAA brackets will be indexed to the consumer price index based on the 12-month CPI change from September through August of the following year. As a result, the income brackets used to determine Medicare surcharges in 2025 will increase by as much as 3%, rounded to the nearest $1,000. Table 12.3 shows the total monthly premiums for high income beneficiaries in 2025.

Table 12.3
Part B IRMAA Premiums for 2025

Based on Modified Adjusted Gross Income (MAGI) from 2023 Federal Tax Return			
Single/Head of Household Filer Income	**Joint Filer Income**	**IRMAA Amount**	**Total Monthly Premium**
$106,000 or less	$212,000 or less	$0.00	$185.00
$106,001 - $133,000	$212,001 - $266,000	$74.00	$259.00
$133,001 - $167,000	$266,001 - $334,000	$185.00	$370.00
$167,001 - $200,000	$334,001 - $400,000	$295.90	$480.90
$200,001 - $500,000	$400,001 - $750,000	$406.90	$591.90
Above $500,000	Above $750,000	$443.90	$628.90

Source: 2025 Medicare Parts A & B Premiums and Deductibles | CMS

Table 12.4 illustrates the 2025 premiums to be paid by (or on behalf of) beneficiaries who are married and live with their spouses at any time during the taxable year but who file separate tax returns.

Table 12.4
Part B IRMAA Premiums MFS, 2025

Married Filing Separately (based on 2023 MAGI)	IRMAA Amount	Monthly Premium
Less than or equal to $106,000	$0.00.	$185.00
Greater than $103,000 and less than $394,000	$406.90	$591.90
Greater than or equal to $394,000	$443.90	$628.90

Source: 2025 Medicare Parts A & B Premiums and Deductibles | CMS

CMS has estimated that over 8.3 million beneficiaries will pay an extra $23.7 billion due to the IRMAA surcharge in 2025. CMS is also projecting that by 2031, 13.5 million beneficiaries will pay a Part B income-relate premium.

Request for IRMAA Reduction Due to Life Changing Event

It's common for Part B enrollees to qualify for a reduction of their IRMAA premium because their income drops by more than one bracket due to a major life changing event (LCE). The problem is that the SSA doesn't know someone is eligible for an IRMAA reduction unless the person notifies the agency.

Part B enrollees have two opportunities to request the Medicare IRMAA reduction from the SSA:

- When they enroll in Medicare Part B for the first time; and
- When they receive their annual Medicare Part B premium and IRMAA notice in the late fall for the following Jan. 1.

Life Changing Events

The SSA will consider granting the request if the Part B enrollee has had a change in circumstance that puts them in a lower MAGI tier than they were two years before. The qualifying events, which apply to the enrollee or their spouse, include:

- Death of spouse (HI 01120.010).
- Marriage (HI 01120.015).
- Divorce or annulment (HI 01120.020).
- Work reduction (HI 01120.025).
- Work stoppage (HI 01120.030).
- Loss of income-producing property (HI 01120.035).
- Loss of employer pension (HI 01120.040); or
- Receipt of the settlement payment from a current or former employer (HI 01120.043).

Examples of Non-Qualifying LCEs

Part B enrollees may experience losses of MAGI or income that are not LCEs. Some examples of events and reductions in MAGI or income that are not LCEs are:

- Ordinary loss of dividend income.
- Higher medical expenses.
- Higher living expenses.
- Loss of child support.
- Loss of alimony; or

- Voluntary sale of income-producing property.

There are situations where a beneficiary may request the use of a more recent tax year for a new initial determination because a one-time event caused an increase in their income for the tax year, we are using to impose IRMAA. Consider this type of event as a non-qualifying event. Some examples of one-time income that cause an increase and are non-qualifying events (NQEs) include:

- Capital gains from the sale of property.
- Lottery winnings.
- Casino winnings.
- Conversion of an IRA; or
- Cashing bonds.

Steps to Take to Apply an IRMAA Reduction

To apply for a Medicare IRMMA reduction, your client needs to:

- Determine if a qualifying event has occurred and resulted in a lower IRMMA bracket; and
- Make an appointment at the local Social Security office to discuss the reduction process or file form SSA-44 Medicare IRMAA Life-Changing Event and associated documentation.

Enrollees should respond within 60 days of receiving the Medicare IRMMA notice. They must be sure to keep a copy and get a dated and stamped receipt for all materials filed at a Social Security office. The agency does not accept U.S. mail or other delivery service confirmations as verification of filing.

Appeal Process

If SSA does not grant the request for the IRMAA reduction, the enrollee can appeal the decision by filing form SSA-561 Request for Reconsideration. In addition, under certain circumstances, an enrollee will need to repeat the process in the subsequent year because the tax return on file still does not reflect that person's current circumstances. Your clients will be glad you guided them through it. Otherwise, they could be leaving thousands of dollars on the table by not pursuing the reduction appropriately.

Part B Deductibles and Coinsurance Amounts

Most services under Part B are subject to an annual deductible and coinsurance. The annual deductible was set by statute through 2005. Thereafter, it increases with the increase in the Part B aged actuarial rate to approximate the growth in per capita Part B expenditures. Table 12.5 shows the historical levels of Part B deductible. In 2025, the

Part B deductible will be $257, an increase of $17 from the annual deductible of $240 in 2024.

Table 12.5
Part B Historical Deductible (1970 – 2025)

Calendar Year	Standard Monthly Premium
1970	$50
1980	$60
1990	$75
2000	$100
2005	$110
2010	$155
2015	$147
2016	$166
2017	$183
2018	$183
2019	$185
2020	$198
2021	$203
2022	$233
2023	$226
2024	$240
2025	$257

Source: SSA, SMI Cost Charing page 198 Table V-E.2
2025 Medicare Parts A & B Premiums and Deductibles | CMS

After meeting the deductible, the beneficiary pays an amount equal to the product of the coinsurance percentage and the remaining allowed charges. The coinsurance percentage is 20 percent for most services. However, since the coinsurance payment for a service paid under the outpatient hospital prospective payment system is capped at the inpatient hospital deductible amount. For those services not subject to the deductible or coinsurance (clinical laboratory tests, home health agency services, and most preventive care services), the beneficiary pays nothing.

Table 12.6 below gives information about what the beneficiary must pay if they have Original Medicare.

Table 12.6
Part B Costs for Covered Services and Items, 2025

Part B Deductible	In 2025, the beneficiary pays the first $257 yearly for Part B-covered services or items.
Blood	In most cases, the provider gets blood from a blood bank at no charge, and the Medicare beneficiary will not have to pay for it or replace it. However, the Medicare beneficiary will pay a copayment for the blood processing and handling services for every unit of blood they receive, and the Part B deductible applies. If the provider has to buy blood for the Medicare beneficiary, they must either pay the provider costs for the first 3 units of blood they receive in a calendar year or have the blood donated by them or someone else. Medicare beneficiary pays a copayment for additional units of blood they receive as an outpatient (after the first 3), and the Part B deductible applies.
Clinical Laboratory Services	Medicare Part B pays 100% of the approved charges. No deductible is required.
Home Health Care Services	Medicare Part B pays 100% of the approved charges. No deductible. However, if using medical equipment (wheelchair, special bed), the Medicare beneficiary must pay 20% of the Medicare-approved amount for durable medical equipment.
Medical and Other Services	Pay 20% of the Medicare-approved amount for most doctor services (including most doctor services while the Medicare beneficiary is a hospital inpatient), outpatient therapy*, most preventive services, and durable medical equipment.
Mental Health Services	Pay 45% of the Medicare-approved amount for most outpatient mental health care.
Other Covered Services	Pay copayment or coinsurance amounts.
Outpatient Hospital Services	Pay a coinsurance or copayment amount that varies by service for each Medicare beneficiary outpatient hospital service. No copayment for a single service can be more than the amount of the inpatient hospital deductible.

Part B Types of Services Covered

There are two kinds of Part B-covered services. They are:

- *Medically necessary services.* Services or supplies that are needed to diagnose or treat a Medicare beneficiary's medical condition and that meets accepted standards of medical practice; and
- *Preventive services.* Health care to prevent illness or detect it early, when treatment is most likely to work best (for example, Pap tests, flu shots, and colorectal cancer screenings).

Trying to learn what is and is not covered can be important because many Medicare beneficiaries may get the most benefits by fitting their medical treatments into the covered categories whenever possible.

For some services, there are no costs, but they may have to pay for the visit to the doctor. If the Part B deductible ($257 in 2025) applies, they pay all costs until they meet the yearly Part B deductible before Medicare begins to pay its share. Then after the deductible has been met, the beneficiary will typically pay 20% of the Medicare-approved amount of the service (known as coinsurance).

Types of Common Services Covered

Here is a list of common services that Medicare Part B covers:

- *Outpatient Hospital Services*. Services a Medicare beneficiary gets as an outpatient as part of a doctor's care. The Medicare beneficiary pays 20% of the Medicare-approved amount for the doctor's services. The Medicare beneficiary may pay more for a doctor's care in a doctor's office. The Medicare beneficiary pays a specified copayment for each service they receive in an outpatient hospital setting. The copayment cannot be more than the Part A hospital stay deductible ($1,676 in 2025). Part B Deductible applies ($257 in 2025).
- *Outpatient Medical and Surgical Services and Supplies*. For approved procedures (like X-rays, a cast, or stitches). The Medicare beneficiary pays 20% of the Medicare-approved amount for the doctor's services. The Medicare beneficiary pays a specified copayment for each service they receive in an outpatient hospital setting. This amount can't be more than the Part A hospital stay deductible ($1,676 in 2025). Part B Deductible applies ($257 in 2025), and the Medicare beneficiary pays all charges for items or services that Medicare doesn't cover.
- *Pap Tests and Pelvic Exams* (includes clinical breast exam). Checks for cervical, vaginal, and breast cancers. Medicare covers these screening tests once every 24 months, or once every 12 months for women at high risk, and for women of childbearing age who have had an exam that indicated cancer or other abnormalities in the past 3 years. No cost to the Medicare beneficiary for the Pap lab test. The Medicare beneficiary pays 20% of the Medicare-approved amount for Pap test specimen collection and pelvic and breast exams. If the pelvic exam was provided in a hospital outpatient setting, Medicare beneficiary pays a copayment.
- *Physical Exam.* A one-time "*Welcome to Medicare*" physical exam and education and counseling about preventive services, including certain screenings, shots, and referrals for other care if needed. Medicare will cover this exam if the Medicare beneficiary gets it within the first 12 months, they have Part B. The Medicare beneficiary pays 20% of the Medicare-approved amount. In a hospital outpatient setting, the Medicare beneficiary pays a copayment. When the Medicare beneficiary makes the appointment, they should let the doctor's office know that they would like to schedule their "Welcome to Medicare" physical exam.

- *Physical Therapy*. Evaluation and treatment for injuries and diseases that change the Medicare beneficiary's ability to function when their doctor certifies that they need it. There may be limits on these services and exceptions to these limits. Medicare beneficiaries pay 20% of the Medicare-approved amount, and the Part B deductible applies ($257 in 2025).
- *Pneumococcal Shot.* Help prevent pneumococcal infections (like certain types of pneumonia). Most people only need this preventive shot once in their lifetime. No cost if the doctor or supplier accepts the assignment for giving the shot.
- *Prescription Drugs* (limited). Includes a limited number of drugs such as injections the Medicare beneficiary gets in a doctor's office, certain oral cancer drugs, drugs used with some types of durable medical equipment (like a nebulizer or infusion pump) and under limited circumstances, certain drugs the Medicare beneficiary gets in a hospital outpatient setting. The Medicare beneficiary pays 20% of the Medicare-approved amount for these covered drugs. If the covered drugs the Medicare beneficiary gets in a hospital outpatient setting are part of the service they receive, they pay the copayment for the services. However, if the Medicare beneficiary gets other types of drugs in a hospital outpatient setting, what they pay depends on whether they have Part D or other prescription drug coverage, whether the Medicare beneficiary drug plan covers the drug, and whether the hospital is in their drug plan's network. Keep in mind that under Part B, the Medicare beneficiary pays 100% for most prescription drugs, unless they have Part D or other drug coverage.
- *Prostate Cancer Screenings.* Help detects prostate cancer. Medicare covers a digital rectal exam and Prostate Specific Antigen (PSA) test once every 12 months for all men with Medicare over age 50. The Medicare beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible ($257 in 2025) applies for the doctor's visit. In a hospital outpatient setting, the Medicare beneficiary pays a copayment. The Medicare beneficiary pays nothing for the PSA test.
- *Prosthetic/Orthotic Items*. Including arm, leg, back, and neck braces; artificial eyes; artificial limbs (and their replacement parts); some types of breast prostheses (after mastectomy); and prosthetic devices needed to replace an internal body part or function when the Medicare beneficiary's doctor orders it. For Medicare to cover prosthetic or orthotic, the Medicare beneficiary must go to a supplier that is enrolled in Medicare. The Medicare beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible ($257 in 2025) applies.
- *Pulmonary Rehabilitation.* Medicare covers a comprehensive pulmonary rehabilitation program if the Medicare beneficiary has moderate to very severe chronic obstructive pulmonary disease (COPD) and has a referral for pulmonary rehabilitation from the doctor treating their chronic respiratory disease. The Medicare beneficiary would pay 20% of the Medicare-approved amount if they received the service in a doctor's office. The Medicare beneficiary pays a copayment per session if they receive the service in a hospital outpatient setting.
- *Rural Health Clinic Services.* Includes many outpatients primary care services. Medicare beneficiary pays 20% of the amount charged, and the Part B deductible ($257 in 2025) applies.

- *Second Surgical Opinions.* Covered in some cases for surgery that isn't an emergency. In some cases, Medicare covers third surgical opinions. Medicare beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible ($257 in 2025) applies.
- *Smoking Cessation* (counseling to stop smoking). Includes up to 8 face-to-face visits in a 12-month period if the Medicare beneficiary is diagnosed with an illness caused or complicated by tobacco use or takes medicine affected by tobacco. Medicare beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible ($257 in 2025) applies. In a hospital outpatient setting, Medicare beneficiary pays a copayment.
- *Speech-Language Pathology Services*. Evaluation and treatment are given to regain and strengthen speech and language skills, including cognitive and swallowing skills, when a doctor certifies the Medicare beneficiary's need. There may be limits on these services and exceptions to these limits. Medicare beneficiaries pay 20% of the Medicare-approved amount, and Part B ($257 in 2025) deductible applies.
- *Surgical Dressing Services.* For treatment of a surgical or surgically treated wound. Medicare beneficiaries pay 20% of the Medicare-approved amount for the doctor's services. Medicare beneficiaries pay a fixed copayment for these services when they receive them in a hospital outpatient setting. Medicare beneficiary pays nothing for the supplies. The Part B deductible ($257 in 2025) applies.
- *Telehealth*. Includes a limited number of medical or other health services, like office visits and consultations provided using an interactive two-way telecommunications system (like real-time audio and video) by an eligible provider who is at a location different from the patients. Available in some rural areas, under certain conditions, and only if the patient is located at one of the following places: a doctor's office, hospital, rural health clinic, federally qualified health center, hospital-based dialysis facility, skilled nursing facility, or community mental health center. Medicare beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible ($257 in 2025) applies.
- *Tests.* Including X-rays, MRIs, CT scans, EKGs, and some other diagnostic tests. Medicare beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible ($257 in 2025) applies. If the test is done at a hospital as an outpatient, Medicare beneficiary pays a copayment that may be more than 20% of the Medicare-approved amount, but it can't be more than the Part A hospital stay deductible ($1,676 in 2025).
- *Transplants and Immunosuppressive Drugs.* Including doctor services for heart, lung, kidney, pancreas, intestine, and liver transplants under certain conditions and only in a Medicare-certified facility. Medicare covers bone marrow and corneal transplants under certain conditions. Immunosuppressive drugs are covered if Medicare paid for the transplant, or an employer or union group health plan is required to pay before Medicare paid for the transplant. Medicare beneficiaries must have been entitled to Part A at the time of the transplant. They must be entitled to Part B when they get immunosuppressive drugs. Medicare beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible ($257 in 2025) applies. **Note:** Medicare drug plans (Part D) may cover

immunosuppressive drugs, even if Medicare or an employer or union group health plan didn't pay for the transplant.

- *Travel* (health care needed when traveling outside the United States) (limited). Medicare generally doesn't cover health care while the Medicare beneficiary is traveling outside the U.S. (the "U.S." includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa). There are some exceptions, including some cases where Medicare may pay for services that the Medicare beneficiary receives while on board a ship within the territorial waters adjoining the land areas of the U.S. In rare cases, Medicare may pay for inpatient hospital, doctor, or ambulance services your client gets in a foreign country in the following situations:
    - If an emergency arises within the U.S., the foreign hospital is closer than the nearest U.S. hospital to treat the medical condition.
    - If the Medicare beneficiary is traveling through Canada without unreasonable delay by the most direct route between Alaska and another state when a medical emergency occurs, and the Canadian hospital is closer than the nearest U.S. hospital that can treat the emergency; and
    - If the Medicare beneficiary lives in the U.S. and the foreign hospital is closer to their home than the nearest U.S. hospital that can treat the medical condition, regardless of whether an emergency exists. The Medicare beneficiary pays 20% of the Medicare-approved amount, and the Part B deductible ($257 in 2025) applies;
- *Urgently Needed Care.* To treat a sudden illness or injury that isn't a medical emergency. Medicare beneficiary pays 20% of the Medicare-approved amount for the doctor's services, and the Part B deductible ($257 in 2025) applies.

Types of Preventive Services Covered

Here is a list of Medicare-covered "preventive services;"

- Abdominal Aortic Aneurysm Screening.
- Bone Mass Measurement.
- Cardiovascular Screenings.
- Fecal Occult Blood Test.
- Colonoscopy.
- Barium Enema.
- Flexible Sigmoidoscopy.
- Diabetes Screenings.
- Diabetes Self-management Training.
- EKG Screening.
- Flu Shots.
- Glaucoma Tests.
- Hepatitis B Shots.
- HIV Screening.
- Mammogram (screening);

- Medical Nutrition Therapy Services; and
- Prostate Cancer Screenings.

Type of Services Not Covered

It is important to remember Medicare does not cover everything. If a Medicare beneficiary needs certain services that Medicare doesn't cover, they will have to pay out-of-pocket unless they have other insurance to cover the costs. Even if Medicare covers a service or item, the Medicare beneficiary generally will have to pay deductibles, coinsurance, and copayments. All of these out-of-pocket costs can add up to a significant amount of money.

Items and services that Medicare doesn't cover include, but aren't limited to:

- Long-term care.
- Routine dental care.
- Dentures.
- Cosmetic surgery.
- Acupuncture.
- Hearing aids; and
- Exams for fitting hearing aids.

Part B Enrollment Periods

Enrollment in Part B (like Part A) can happen automatically or during three different types of enrollment periods. They are:

- Automatic Enrollment Period.
- Initial Enrollment Period.
- General (Open) Enrollment Period; and
- Special Enrollment Period.

Automatic Enrollment Period (AEP)

If the beneficiary is receiving Social Security benefits prior to age 65, they should be automatically enrolled in Part B. Coverage begins the first day of their birth month if they are 65 years old, or the first day of the 25th month of recurring benefits:

- The beneficiary will receive a Medicare card in the mail from Social Security three months before their 65th birthday notifying them of enrollment in Medicare Part A and Part B. If they do not want Part B, they must return the card appropriately marked, and they will be enrolled for Part A coverage only; or
- If no card is received, the beneficiary should contact their nearest Social Security Administration office prior to their 65th birthday.

Initial Enrollment Period

The initial enrollment period applies if they are just turning 65 and have not received Social Security benefits. The seven-month initial enrollment period begins three months prior to their birth month and ends three months following their birth month (see Table 12.7).

Table 12.7
Initial Enrollment Period

Month 1	Month 2	Month 3	Birth Month	Month 5	Month 6	Month 7

The month of enrollment determines when Medicare coverage becomes effective:

- Beneficiary coverage will begin the first day of the month after the beneficiary signed up They may also have to pay a higher premium for late enrollment (discussed below):

General Enrollment Period

The general (open) enrollment period is an annual enrollment opportunity if the beneficiary did not sign up for Part B during the initial enrollment period. General enrollment runs from January 1 through March 31st each year (see Table 12.8).

Table 12.8
General Enrollment Period

January	February	March	Coverage begins on the first day of month after you sign up.

- Beneficiary coverage will begin the first day of the month after the beneficiary signed up They may also have to pay a higher premium for late enrollment (discussed below).

Special Enrollment Period (SEP)

The special enrollment period will apply if the beneficiary continues to work past age 65 and is covered under an employer group health plan (EGHP). The beneficiary must notify Social Security of their intent to remain covered by the employer group health plan (EGHP). The beneficiary may enroll at any time after age 65. Still, they must enroll no later than eight (8) months after the month of their retirement or of the person who is working. The beneficiary also can enroll anytime during the year while they are still working if they decide they want Medicare coverage or if their EGHP is discontinued. If they enroll in any other month, coverage begins the month following. If they are eligible

for special enrollment, they are not penalized with a 10 percent surcharge, provided they enroll no later than eight months after the month of retirement.

This Special Enrollment Period doesn't apply to people with End-Stage Renal Disease (ESRD). If the beneficiary is receiving Medicare because of End-Stage Renal Disease (ESRD), they can sign up for Part B when they sign up for Part A. If they delay signing up for Part B, they can only get it during the general enrollment period, and they will have to pay a late enrollment penalty.

In addition, the SEP does not apply to those workers who use COBRA. If an individual signs up for COBRA and waits until their coverage expires to enroll in Part B, they will be disqualified from using the eight-month grace period. Why? Because the law states that an employer group health plan must have covered the individual.

COBRA is not an employer group health plan. Instead, the individual now must wait to sign up during the general (open) enrollment period from Jan. 1 to March 31 each year. Their coverage won't begin until July 1 of that year. They also get hit with a late penalty; an extra charge added permanently to their Part B premiums (discussed below).

Already Enrolled in Medicare

If the beneficiary is already enrolled in Part A and they want to sign up to Part B, they must complete Form CMS-40B, Application for Enrollment in Medicare – Part B (medical insurance). If the benficiary is applying for Medicare Part B due to a loss of employment or group health coverage, they will also need to complete form CMS-L564, Request for Employment Information.

Note: When completing the forms CMS-40B and CMS L564, state "I want Part B coverage to begin (MM/YY)" in the remarks sectikon of the CMS-40B. If possible the beneficiary's employer should complete Section B.

Part B Late Enrollment Fees

Like Part A, if the beneficiary does not sign up for Part B when they are first eligible, they may have to pay a late enrollment penalty for as long as they have Medicare. The monthly premium for Part B may go up 10% for each full 12-month period that they could have had Part B but didn't sign up for it. Usually, the beneficiary does not have to pay a late enrollment penalty if they had signed up for Part B during the special enrollment period (SEP).

So, for example, if someone were eligible for Medicare Part B in 2022 but waited until 2025 to enroll, they would face a 30% enrollment penalty because they waited three years to enroll. This late penalty will have to be paid for as long as the individual is enrolled in Part B. Based on the 2025 monthly premium of $185.00 per month, this individual who waited 3 years to enroll incurred a 30% penalty of $55.50, increasing the monthly Part B premium to $240.50.

Note: If your client is aged 65 or older, after signing up for Part B, they have a 6-month Medigap open enrollment period, giving them a guaranteed right to buy a Medigap (Medicare Supplement Insurance) policy.

Further Reading

2024 Medicare Parts A & B Premiums and Deductibles October 12, 2023
www.cms.gov/newsroom/fact-sheets/2024-medicare-parts-b-premiums-and-deductibles

2025 Annual Report of The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds
2025 Medicare Trustees Report (cms.gov)

Social Security Administration, *What You Can Do if You Think Your Medicare Income-Related Premium is Incorrect*; https://www.ssa.gov/pubs/EN-05-10125.pdf

Social Security Administration, *Medicare Premiums: Rules for Higher-Income Beneficiaries*; https://www.ssa.gov/pubs/EN-05-10536.pdf

Chapter 12
Review Questions

1. Medicare Part B is referred to as:

( ) A. Supplementary Medical Insurance
( ) B. Hospital Insurance
( ) C. Medical Advantage
( ) D. Inpatient Care

2. Which of the following sets the standard Medicare Part B premium at 25% of estimated program costs?

( ) A. Centers for Medicare and Medicaid
( ) B. State Medicaid Departments
( ) C. Department of Health and Human Services
( ) D. The Balanced Budget Act of 1997

3. Which of the following services will not be covered by Medicare Part B?

( ) A. Dental care
( ) B. Second Surgical Opinions
( ) C. Pap tests
( ) D. Surgical dressing services

4. Under Part B, what is the beneficiary's coinsurance percentage amount?

( ) A. 75%
( ) B. 80%
( ) C. 20%
( ) D. 25%

5. When will Part B coverage begin if a beneficiary signs up during the general enrollment period (GEP)?

( ) A. The first month after signing up
( ) B. June 1 of the following year
( ) C. July 1 of that year
( ) D. September 1 of the following year

CHAPTER 13

MEDICARE ADVANTAGE PLANS (PART C)

Overview

Medicare Advantage (MA), also known as Medicare Part C, is the private insurance option for Medicare beneficiaries. Since the 1970s, Medicare beneficiaries have had the option to receive their Medicare benefits through private health plans, mainly health maintenance organizations (HMOs), as an alternative to the federally administered traditional (Original) Medicare program (Parts A and B). MA plans provide all hospital and related services covered by Medicare Part A and the physician and outpatient services covered by Part B. Some MA plans include prescription drugs, known as MA-PD.

This chapter provides an overview of the Medicare Advantage (MA) program. It will examine the history of MA plans, the reason for their development, and the growth of the enrollment over the past decade. It will also examine the various types of MA plans, their benefits, current enrollment, when they were developed and why, and their enrollment over the past decade.

Learning Objectives

Upon completion of this chapter, you will be able to:

- Relate the basic rules of Medicare Advantage plans.
- Describe the various types of Medicare Advantage plans.
- Distinguish the differences between HMOs, PPOs, and MSAs.
- Determine the coverage and eligibility rules for the various MA plans.
- Outline the costs, premiums, deductibles, and copayments.
- Identify the reasons why a Medicare Beneficiary may want to choose an MA Plan instead of Original Medicare (Part A & Part B); and
- Observe the enrollment dates.

History of MA Plans

The original form of what is now known as a Medicare Advantage (MA) plan was the Medicare risk contract that was part of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. The risk contract, which is still in use today in a modified or evolved form, utilizes a methodology wherein an HMO assumes all the insurance risk from the

government and is paid a fixed monthly payment by the Centers for Medicare and Medicaid Services (CMS) to cover all the costs of electing beneficiaries associated with the traditional Medicare benefit. In addition, it frequently enhances benefits such as prescription drugs, eyeglasses, reduced copays, and deductibles. Then, the HMO often contracts with provider organizations, such as physician groups or integrated health systems, on a prepaid or capitated basis to provide all health services to the enrolled Medicare beneficiaries. To qualify as the "insurer" under relevant federal and state law, the HMO retains a portion of the monthly payment for itself along with sufficient insurance. These risk contracts can be, and often are, very profitable for both the HMO and the provider organizations.

The Balanced Budget Act of 1997

The Balanced Budget Act of 1997 (BBA) created a new Part C of the Medicare program, known as "Medicare+Choice" (M+C), that significantly expanded the health care options available to Medicare beneficiaries. Beginning January 1, 1999, eligible individuals could begin to receive Medicare benefits through enrollment in one of an array of private health plan choices beyond the Original Medicare program (Parts A and B) or the plans that were available through Managed Care Organizations under section 1876 of the Social Security Act (referred to as 1876 cost plans).

Prior to BBA of 1997, Medicare risk contractors received 95 percent of the adjusted average per capita cost (AAPCC) of traditional Medicare's fee-for-service (FFS) cost in their county of operations, which was supposed to save the federal government 5 percent. However, the AAPC reflected only adjustments for age, sex, institutional Medicaid eligibility, and disabled status. These criteria were shown in research studies to account for only 1 percent of the variation in Medicare spending for beneficiaries. Further, because the HMOs were shown to enroll healthier elderly insureds compared to the traditional Medicare program, the risk contract cost the federal government money, rather than saving the 5 percent implied in the 95 percent formula.

The effect of this original formula was to increase payments to Medicare HMOs at the same rate as spending in traditional Medicare, often resulting in substantial profits. After the BBA, the payment was linked to a formula that generally resulted in Medicare risk contractors receiving an annual increase from the 1997 base year of only 2 percent per annum. Subsequent legislation granted a special one-time increase of 3 percent in 2000.

Medical contractors under the BBA and hospital services increased more rapidly. This eroded some of the profits earned by HMOs and provider organizations that participated in the program. In some instances, significant losses were incurred, and the providers dropped out of the risk contract program.

Medicare and the Medicare Modernization Act of 2003

The Medicare+Choice program was renamed Medicare Advantage and significantly expanded to more traditional private market insurance programs in the "*Medicare Modernization Act (MMA) of 2003* signed into law by President George W. Bush,

including private fee-for-service plans and preferred provider organizations (PPOs–described below).

Medicare HMOs under the Medicare+Choice program declined steadily after the BBA. According to the House/Senate Conference Report on the 2003 Medicare Modernization Act, enrollment fell from 6.2 million beneficiaries in 1998 to 4.6 million beneficiaries in November 2003. The number of plans decreased from 346 to 155. As a result of the MMA legislation and recommendations by the Medicare Payment Advisory Council (MedPAC), commencing in 2004, payments for all plans were paid at a rate at least as high as the rate for traditional FFS Medicare (before giving effect to the severity-of-illness adjusters). After 2004, private plans' capitation rates grew at the same rates as FFS Medicare.

Under the MMA, existing Medicare+Choice plans were paid a per capita rate (excluding severity of illness adjusters) by county, set at the highest of three amounts:

- A minimum payment (or floor) rate.
- A rate calculated as a blend of an area-specific (local) rate and a national rate; and
- A rate reflecting a minimum increase from the previous year's rate (currently 2 percent).

Health plans and providers had been confronted with a 2 or 3 percent annual increase in revenue while costs increased at double-digit rates. This was compounded in large part by the negotiating strategy of hospitals which, dissatisfied with fee-for-service Medicare inpatient and outpatient rates, attempted to recover these losses through negotiations with the health plans in capitated Medicare and commercial insurance products.

Effective in 2006, the MMA requires MA plans to submit bids to the government that provides an estimate of the per-enrollee cost for the Medicare-covered services described earlier would be in each county they operate. If the bid exceeds the benchmark established by CMS for that county, beneficiaries enrolling in the MA plan are charged a premium for the difference, and the federal government gets the other 25 percent as a saving. The plan was, in turn, required to rebate the 75 percent and enrollee benefits.

Under the MMA, plans must provide reduced cost-sharing, additional benefits, or reduced Part B premiums valued at 100 percent of the difference between the projected cost of providing Medicare-covered services to its commercial population and the expected revenue for Medicare enrollees. The legislation also requires a plan to provide an enrollee with a monthly rebate equal to 75 percent of any average per capita savings, based upon the adjusted community rate (ACR) proposal that health plans are required to submit. The beneficiary rebate can be credited toward providing supplemental health care benefits, including reducing cost-sharing, additional benefits, or a credit toward any plan monthly supplemental beneficiary premium, the prescription drug premium, or the Part B premium. The federal government will retain the remaining 25 percent of the average per capita savings.

Affordable Care Act 2010

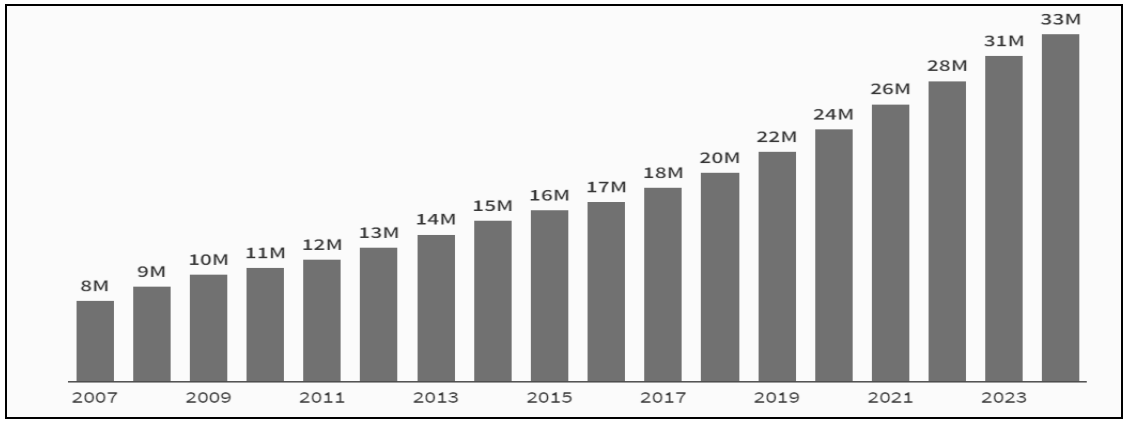
The ACA of 2010 revised the methodology for paying plans and reduced the benchmarks. For 2011, benchmarks were frozen at 2010 levels. Reductions in benchmarks were phased in over 2 to 6 years between 2012 and 2016. Then in 2017, when the new benchmarks were fully phased-in, the benchmarks ranged from 95% of traditional Medicare costs in the top quartile of counties with relatively high per capita Medicare costs to 115% of traditional Medicare costs in the bottom quartile of counties with relatively low Medicare costs.

The ACA specified that plans with higher quality ratings would receive bonus payments added to their benchmarks, beginning in 2012. The ACA also reduced rebates for all plans but allowed plans with higher quality ratings to keep a larger share of the rebate than plans with lower quality ratings. Plans that receive a rating of four stars or higher can increase their payments by up to 5%. CMS has continued to offer quality bonuses to high-performing plans. Over time, most plans have improved their star ratings and enrolled more beneficiaries. This has led to an overall increase in performance revenue received by MA plans–between 2015 and 2023, bonus payments to plans increased from $3.0 billion to $13 billion, an increase of nearly 30% since 2022.

Medicare Advantage (MA) Plan Enrollment

Since 2006, the role of Medicare Advantage, the private alternative to traditional Medicare, has been on a steady climb for the past two decades following changes in policy designed to encourage a robust role for private plan options in Medicare. According to the Kaiser Family Foundation (KFF) report: *Medicare Advantage in 2024: Enrollment Update and Key Trends*, published August 2024, it reported an estimated 32.8 million people out of 61.2 million Medicare beneficiaries with both Medicare Parts A and B – are enrolled in Medicare Advantage plans (see Figure 13.1).

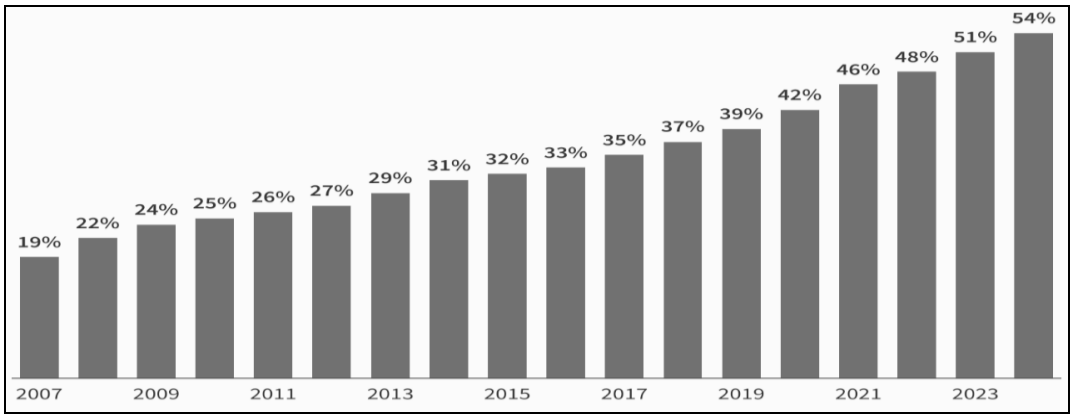
Figure 13.1
Medicare Advantage Enrollment



Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2024
Medicare Advantage in 2024: Enrollment Update and Key Trends | KFF

Medicare Advantage enrollment as a share of the eligible Medicare population has jumped from 19% in 2007 to 54% in 2024 (see Figure 13.2)

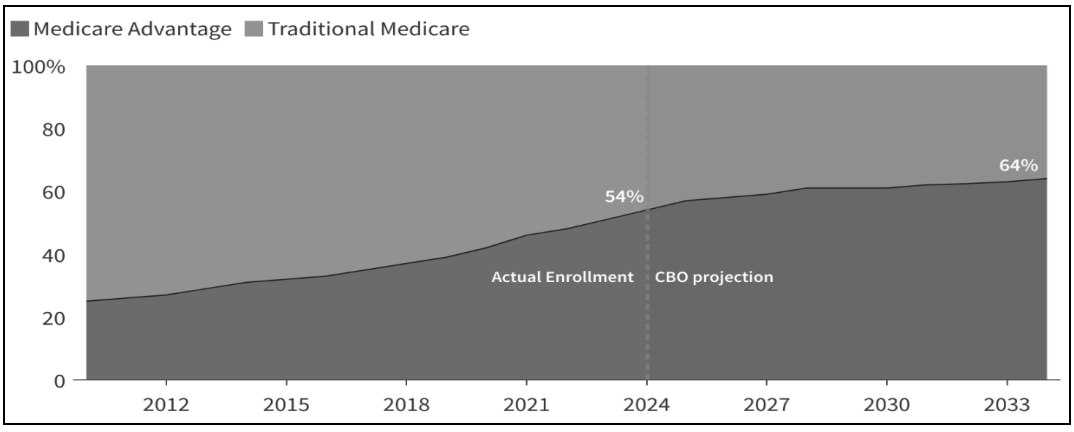
Figure 13.2
Total Medicare Advantage Enrollment, 2007-2024



Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2024
Medicare Advantage in 2024: Enrollment Update and Key Trends | KFF

Between 2023 and 2024, total Medicare Advantage enrollment grew by about 2.1 million beneficiaries, or 7 percent – a similar growth rate as the prior year (8%). The Congressional Budget Office (CBO) projects that the share of all Medicare beneficiaries enrolled in Medicare Advantage plans will rise to 64% by 2034 (Figure 13.3).

Figure 13.3
Medicare Advantage and Traditional Medicare Enrollment, Past and Projected

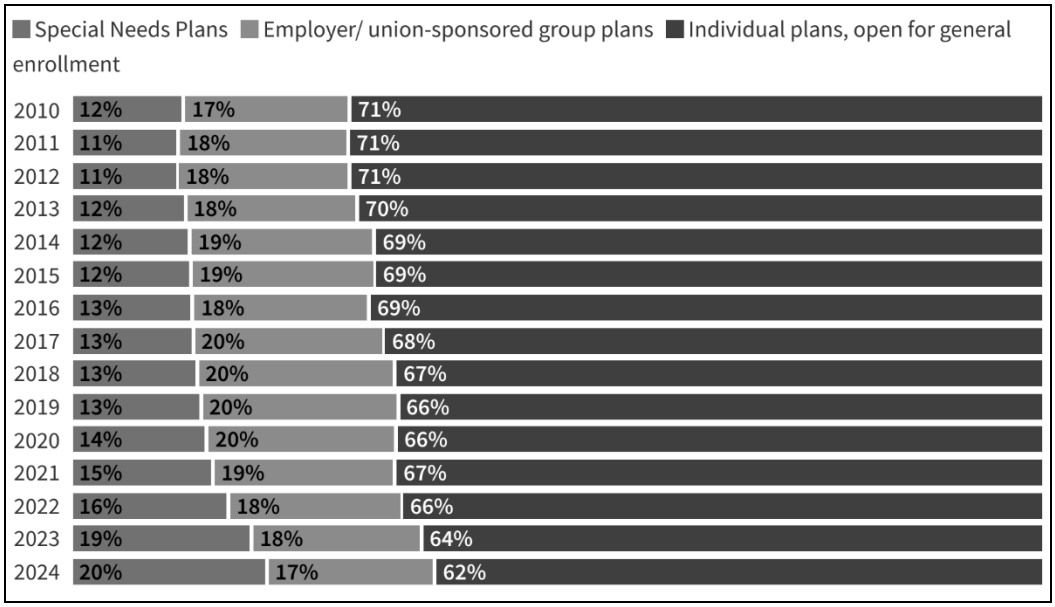


Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2024; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; CCW data from 100 percent of beneficiaries, 2021-2022, and Medicare Enrollment Dashboard 2023-2024. Enrollment numbers from March of the respective year. Projections for 2025 to 2034 are from the June Congressional Budget Office (CBO) Medicare Baseline for 2024.

Medicare Advantage Plan Types

In 2024, nearly two-thirds of Medicare Advantage enrollees were in individual plans that were open for general enrollment. More than 6 of 10 Medicare Advantage enrollees (62%), or 20.5 million people, are in plans generally available to all beneficiaries for individual enrollment (Figure 13.4). That is an increase of 0.9 million enrollees compared to 2023. Individual plans have declined as a share of total Medicare Advantage enrollment since 2010 (71%).

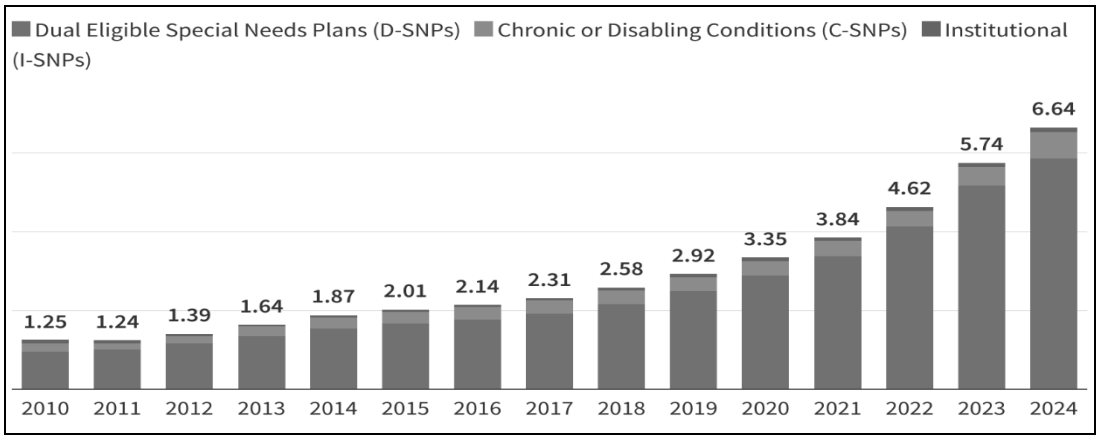
Figure 13.4
Distribution of Medicare Advantage Enrollees by Plan Type, 2024



Note: Percentages may not sum to 100% due to rounding.
Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2021-2024

More than 6.6 million Medicare beneficiaries are enrolled in special needs plans (SNPs) in 2024, more than double the enrollment in 2019. SNPs restrict enrollment to specific types of beneficiaries with significant or relatively specialized care needs, or who qualify because they are eligible for both Medicare and Medicaid. Enrollment in SNPs increased by 16 percent between 2023 and 2024, and accounts for 20 percent of total Medicare Advantage enrollment in 2024, an increase from 12 percent in 2010. Since 2019, SNP enrollment has more than doubled from 2.92 million to 6.64 million (Figure 13.5). This increase is due in part to the increasing number of SNP plans available on average and more dual eligible individuals having access to these plans.

Figure 13.5
Number of Beneficiaries in Special Needs Plans, 2010 - 2024



Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2024.

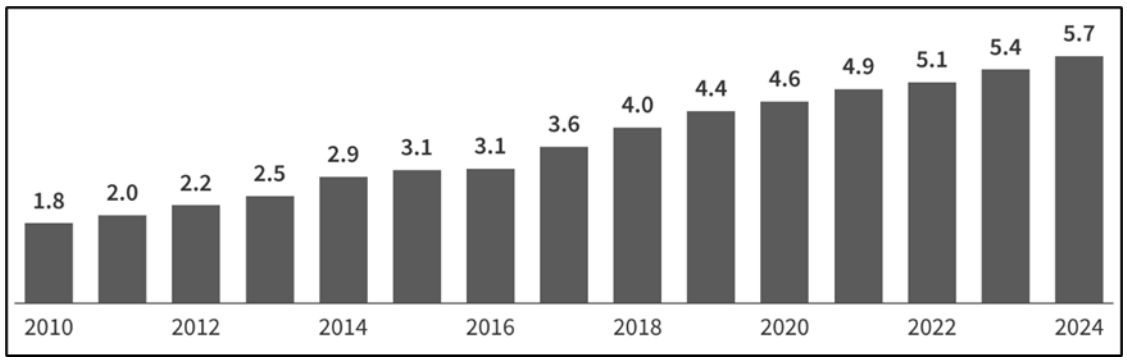
SNP enrollment varies across states. In the District of Columbia and Puerto Rico, SNP enrollees comprise about half of all Medicare Advantage enrollees (49% in DC and 51% in PR). In nine states, SNP enrollment accounts for at least a quarter of Medicare Advantage enrollment: 46% in MS, 34% in AR, 33% in LA and NY, 28% in FL and GA, and 25% in CT, SC and AL.

C-SNP enrollment in 2024 (about 675,000 people) is 45% higher than it was in 2023 – an increase of about 210,000 enrollees. Nearly all (97%) C-SNP enrollees are in plans for people with diabetes or cardiovascular conditions in 2024. Enrollment in I-SNPs has been increasing slightly, with approximately 115,000 enrollees in 2024, up from about 103,000 in 2023.

Slightly less than one in five (17% or about 5.7 million) Medicare Advantage enrollees are in a group plan offered to retirees by an employer or union.

Group enrollment as a share of total Medicare Advantage enrollment has fluctuated between 17% to 20% since 2010, but the actual number has increased from 1.8 million in 2010 to 5.7 million in 2024 (see Figure 13.6). With a group plan, an employer or union contracts with an insurer and Medicare pays the insurer a fixed amount per enrollee to provide benefits covered by Medicare. For example, 13 states provide health insurance benefits to their Medicare-eligible retirees exclusively through Medicare Advantage plans.

Figure 13.6
Number of Beneficiaries in Employer Group or Union-Sponsored Health Plans, 2020 – 2024



Note: Employer group or union-sponsored health plans do not reflect arrangements where the employer provides a subsidy for retirees to use toward premiums or cost sharing for a plan purchased on an individual Medicare Advantage marketplace.
Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2024

Medicare Advantage Benefits

Next, let's discuss some of the benefits of choosing an MA plan:

- *Coverage.* MA plans include Medicare Part A (in-patient and hospitalization coverage, Medicare Part B (outpatient and physician coverage) and may include prescription drug coverage (MA-PD) or can be offered without coverage. MA plans may also include supplemental health benefits such as vision, dental, hearing, and vision screening, and non-health-related benefits such as meal delivery and non-health-related transportation (discussed below);
- *Cost.* While getting extra coverage benefits, the enrollees' out-of-pocket costs are less with a MA plan than if they chose a traditional Medicare and a Medigap policy. Everyone in an MA plan must pay the same monthly premium as those enrolled in Medicare Part B. From that point, an enrollee's cost will depend on the benefits provided by the plan. Some plans don't require the enrollee to pay an extra premium (referred to as $0 cost MA plans) but have deductible and copayment requirements. Other MA plans may charge a premium but have lower deductibles and copayments (discussed later in the chapter). In addition, MA plan enrollees should also compare each plan's out-of-pocket maximum costs, the most an enrollee who stays within a plan's network can pay out-of-pocket (discussed below); and
- *Convenience.* MA plans offer more convenience than traditional Medicare, Medigap, and Part D coverage. By having all health coverage under one umbrella, an enrollee doesn't have to worry about coordinating benefits between different plans and providers. All statements, bills, etc., will come from only one source.

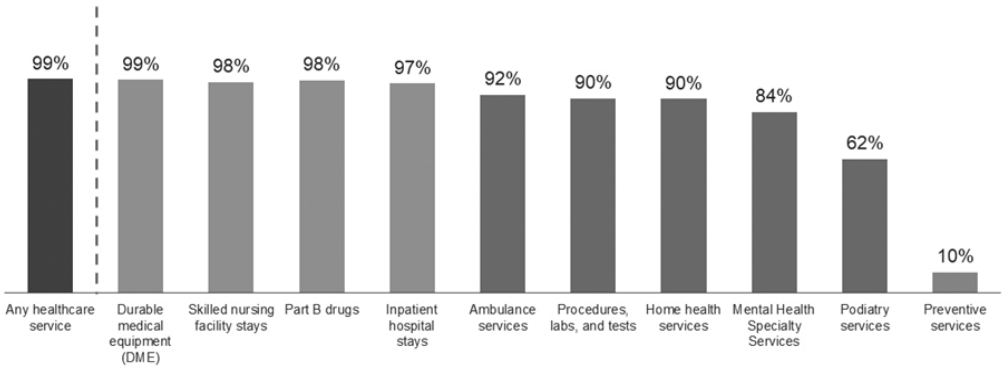
As with anything else in life, MA plans may not meet all your client's needs. When evaluating Medicare options, you should apply the three Cs (coverage, cost, and convenience) to see whether traditional (Original) Medicare measures up to your client's particular needs.

MA Plans Require Prior Authorization

MA plans can require enrollees to receive prior authorization (PA) before service is covered. Nearly all MA enrollees (99%) were in plans that required PA for some services in 2021 (see Figure 13.7). These range from inpatient hospital and skilled nursing facility stays to diagnostic procedures to select vision, hearing, and dental services. Ninety percent or more of MA enrollees require PA for the services named above as well as for durable medical equipment, Part B drugs, non-emergency ambulance services, diabetic supplies and services, and home health. PA can also apply to services one might not consider, such as podiatry (required across 63% of MA plans). The number of enrollees in plans that require PA for one or more services increased from 2019 to 2022, from 79% in 2019 to 99% in 2022. In contrast to MA plans, traditional Medicare does not generally require prior authorization for services. It does not require step therapy for Part B drugs.

Most enrollees must receive PA for the highest cost services, and fewer need to receive it for preventive services.

Figure 13.7
Share of MA Enrollees Required to Receive Prior Authorization, By Service



Types of MA Health Plans

Medicare contracts with insurers to offer the following different types of health plans:

- Health Maintenance Organizations (HMO) Plans.
- Preferred Provider Organization (PPO) Plans.
- Medical Savings Account (MSA) Plans; and
- Special Needs Plans (SNP).

Other less common types of MA plans include:

- *Point of Service (POS) Plans*–like HMOs, but your client may be able to get some services out-of-network for a higher cost; and
- *Provider Sponsored Organizations (PSO) Plans*–run by a provider or group of providers. In a PSO, your client will usually get their health care from the providers of the plan.

According to CMS, local HMOs, and PPOs contract with provider networks to deliver Medicare benefits. HMOs accounted for the majority (62%) of total MA enrollment; local PPOs and regional PPOs accounted for 30%, PFFS 1%, and other 4%.

Next, let's review each of these MA plans in greater detail.

Health Maintenance Organizations (HMO) Plans

HMOs are wellness-based MA plans and usually have the most restrictive healthcare provider network, meaning that a member's healthcare costs may be considerably higher if they go outside of their plan's established network. On average, HMO plans are the lowest priced ($18 per month). HMOs accounted for about six in ten plans (56%) but have declined as a share of all Medicare Advantage plans since 2017 (71% of plans).

HMO plans provide its members, who are also Medicare beneficiaries, either directly or through an arrangement with others, at least all the Medicare-covered services available to Medicare beneficiaries who are not enrolled in the HMO who reside in the geographic area serviced by the HMO. Some HMOs also provide services not covered by Medicare, either free to the Medicare beneficiary (funded out of the payment Medicare makes to the HMO) or additional charges. HMOs typically charge a set monthly premium and nominal copayments for services instead of Medicare's coinsurance and deductibles.

Each HMO-managed care plan has its own network of hospitals, skilled nursing facilities, home health agencies, doctors, and other professionals. Depending on how the plan is organized, services are usually provided at centrally located health facilities or in the doctors' and other health care professionals' private practice offices. As a member, the beneficiary generally must receive all covered care through the plan or from health care professionals referred to by the plan.

Most HMO-managed health care plans will allow the beneficiary (enrollee) to select a primary care physician (PCP) from those parts of the plan. If they do not select, one will be assigned. The primary care physician (PCP) is responsible for managing their medical care, including admitting them, if necessary, to a hospital or referring them to specialists. The beneficiary (enrollee) will be allowed to change their primary care physician if another primary care physician affiliated with the plan is selected.

Before they consider enrolling in an HMO managed care plan, the beneficiary (enrollee) should find out whether the plan has a "risk" or a "cost" contract with Medicare. There is an important difference.

- *Risk Plans.* These plans have "lock-in" requirements. This means that the beneficiary (enrollee) will generally be locked into receiving all covered care through the plan or referrals. In most cases, if the beneficiary (enrollee) receives services that are not authorized by the plan, neither the plan nor Medicare will pay. The only exception that is recognized by all Medicare-contracting plans is for emergency services, which the beneficiary (enrollee) may receive anywhere in the United States, and for services they urgently need when temporarily out of the plan's service area; or
- *Cost Plans.* These plans do not have "lock-in" requirements. If the beneficiary (enrollee) chooses to enroll in a cost plan, they can either go to health care providers affiliated with the plan or go outside the plan. If the beneficiary (enrollee) chooses to go outside the plan, the plan probably will not pay, but Medicare will pay its share of charges it approves. The beneficiary (enrollee) will be responsible for Medicare's coinsurance, deductibles, and other charges, just as they received care under the regular Medicare program. Local HMOs are often very affordable compared to other MA plans because the restrictive network and focus on wellness helps to control healthcare costs.

Preferred Provider Organization (PPO) Plans

Preferred provider plans refer to physicians, hospitals, and other healthcare providers. The health plan has established a contractual agreement for fees. PPOs generally permit a beneficiary (enrollee) to see both in-network and out-of-network providers and, in contrast to HMOs, enrollees do not have to choose a Primary Care Physician (PCP) (see Table 13.8).

Private insurance companies offer Medicare PPO plans. Medicare will pay a set amount of money every month to the private insurance company that provides health care to Medicare beneficiaries who choose an MA PPO plan.

Some MA PPO plans offer prescription drug coverage. Some plans also offer additional benefits, such as vision and hearing screenings, disease management, and other services not covered under Original Medicare. Monthly premiums and how much they will pay will vary depending on the plan they choose.

There are two types of MA PPO Plans. They are:

- *Local Preferred Provider Organizational Plans*–these plans serve the counties the PPO plan chooses to include in its service area; or.
- *Regional Preferred Provider Organizations Plans*–these plans serve one of the 26 regions established by Medicare (these may be a single state or multi-state area).

The availability of local PPOs has increased rapidly over recent years. The share of Medicare Advantage plans that are local PPOs have increased in 2025 to 43% from 24% in 2017. The share of plans that are regional PPOs has slowly declined from around 3%

of plans offered in 2017 to 1% in 2025, while the number of private fee-for-service plans has also continued to decline.

Regional PPO plans have added protection for Medicare Part A (HI) and Part B (Medical Insurance) benefits. There will be an annual limit on their out-of-pocket costs. This limit varies depending on the plan.

When comparing costs, regional PPOs tend to have higher premiums on average compared to local PPOs. For example, in 2024, regional PPOs had an average premium of $49 per month, while local PPOs averaged about $20 per month.

These distinctions are important for beneficiaries when choosing a plan, as local PPOs may offer a more affordable option within a smaller network, while regional PPOs provide more flexibility with a larger provider base but typically at a higher cost.

Note: Medicare beneficiaries can get Medicare prescription drug coverage from their Medicare PPO plan (if their plan offers prescription drug coverage). Insurance companies offering a MA PPO plan are required to offer a plan that includes Medicare prescription drug coverage. If they join a MA PPO plan that doesn't include such coverage, they are not allowed to join a Medicare prescription drug plan

Table 13.8
Comparison of HMOs, PPOs, and Original Medicare Plans

	HMO	PPO	Original Medicare
Premiums: Will the beneficiary (enrollee) have to pay more than the monthly Part B premium to be in the plan?	Generally, yes	Generally, yes	No
Extra benefits: Does the plan cover more benefits than Medicare Part A and Part B?	Generally, yes	Generally, yes	No, unless your client buys a Medigap policy to cover services Original Medicare doesn't cover
Providers: Can the beneficiary (enrollee) go to providers who aren't part of the plan's network?	Generally, no	Yes, but if the Medicare beneficiary (enrollee) goes out-of-network providers, they will usually have to pay more.	Yes

Private Fee-for-Service Plans (PFFS)

A Private Fee-For-Service (PFFS) plan is a MA health plan, offered by a state-licensed risk-bearing entity, which has a yearly contract with the Centers for Medicare & Medicaid Services (CMS) to provide beneficiaries (enrollees) with all their Medicare benefits, plus any additional benefits the company decides to provide. The PFFS plan:

- Pay providers on a fee-for-service basis without placing the providers at financial risk.
- Varies provider payment rates only based on the specialty or location of the provider or to increase utilization of certain preventive or screening services.
- Does not restrict members' choices among providers that are lawfully authorized to furnish services and accept the plan's terms and conditions of payment; and
- Does not permit the use of prior authorization or notification.

Medical Savings Accounts

MA MSA Plans (offered by private companies) are one of the newest MA plan options available for getting Medicare healthcare benefits. Joining a Medicare MSA Plan is optional and is only an option if your client lives in an area that offers Medicare MSA Plans.

If the beneficiary chooses this type of plan, it will give them some control of their own health care dollars. MA MSA Plans are like Health Savings Account (HSA) plans available outside of Medicare. If they choose an MA MSA Plan, they are still in the Medicare program and are entitled to all Medicare benefits.

MA MSA plans have two parts:

- *Health plan*. The first part of an MA MSA Plan is a special type of high-deductible plan. The plan will only begin to cover their costs once they meet a high yearly deductible, which varies by plan; and
- *Savings account*. The second part of an MA MSA plan is a special type of savings account. They would set up a special account with either a bank or a brokerage account which their plan selects. The MA plan deposits money into their account (they cannot add any of their personal funds into this account). When they need health care services, they will withdraw from this savings account to pay their health care costs before they meet the deductible. When they use the money from this savings account (deposits and interest) to pay for medical expenses, the funds withdrawn are tax-free, but only Medicare-covered Part A and Part B services count towards their deductible. If they use the money in this savings account for expenses other than qualified medical expenses, they will be taxed as income, and there may be an additional penalty of 50%.

MA plans provide the beneficiary with Medicare Part A and Part B coverage. If they decide to join an MA MSA Plan, they will get their Medicare-covered health care through a high-deductible MA plan (this plan will only pay for Medicare-covered services once they have reached their deductible). They won't have to pay a monthly premium for this plan because it's a high-deductible type of plan.

However, they will have to continue to pay the Medicare Part B premium. Before they meet the deductible, they will be responsible for paying the costs for any Medicare-covered services. The beneficiary then has the option of using the funds in their savings account to pay these bills. Once they meet the plan's deductible, the plan pays for Medicare-covered services. The high yearly deductible can vary by plan. (The yearly deductible is the amount of Medicare-covered health care costs they must have paid for out-of-pocket or by using the funds in their account before their plan coverage begins.) It's important to know the amount of deductible before they join. Some plans may cover extra benefits for an extra cost, like dental, vision, or long-term care not otherwise covered by Medicare.

Note: MA MSA Plans do not cover Medicare Part D prescription drugs. If they join a Medicare MSA Plan, they can also join a Medicare Prescription Drug Plan to add drug coverage.

People with both Medicare Part A and Part B can generally join an MA MSA Plan. They cannot join a MA MSA Plan if any of the following apply to them:

- They have health coverage that would cover the Medicare MSA Plan deductible, including benefits under an employer or union group health plan.
- They get benefits from the Department of Defense (TRICARE) or the Department of Veterans Affairs.
- They are retired federal government employees and part of the Federal Employee Health Benefits Program (FEHBP).
- They are eligible for Medicaid (a joint federal and state program that helps with medical costs for some people with limited income and resources).
- They have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). However, if they are a former enrollee of a MA Plan that left the Medicare Program and they haven't joined another Medicare Advantage Plan, they can join a MA MSA Plan even if they have End-Stage Renal Disease.
- They are currently getting hospice care; or
- They live outside the United States more than 183 (total) days a year. This is a basic explanation of Medicare MSA Plans. There are rules about MA MSA Plans, like how they can be used, when money is taxed, and when the beneficiary can join or leave the plan.

For more detailed information about MA MSA plans, you or your clients can go to: https://www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/medicare-medical-savings-account-msa-plan

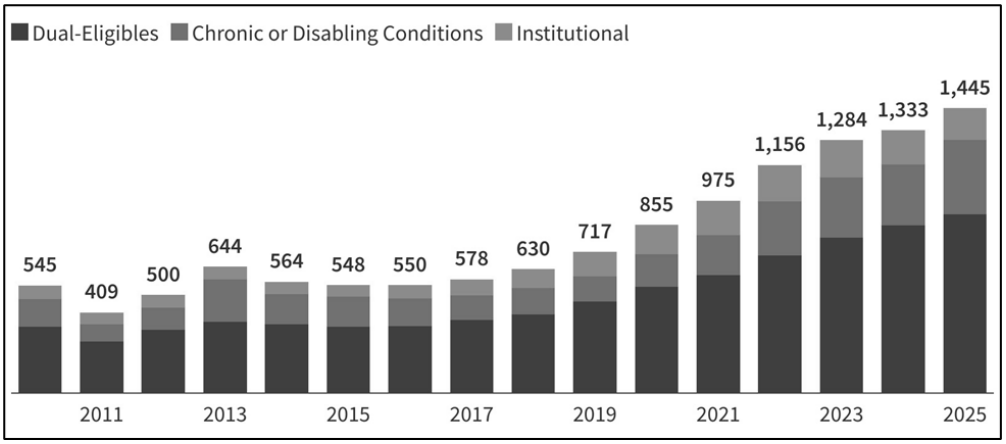
Special Needs (SNP) Plans

Medicare Special Needs Plans (SNPs) are a type of MA plan that is restricted to beneficiaries who:

- Are dually eligible for Medicare and Medicaid.
- Live in long-term care institutions (or would otherwise require an institutional level of care; or
- Have certain chronic conditions.

In 2025, 1,445 SNPs will be offered nationwide, an 8 percent increase between 2024 and 2025 (see Figure 13.9).

Figure 13.9
The Number of Special Needs Plans Has More Than Doubled Since 2018
Number of Special Needs Plans (SNPs), by Plan Type, *2010-2025*



Note: Includes only Special Needs Plans.
Source: KFF analysis of CMS
https://www.kff.org/medicare/issue-brief/medicare-advantage-2025-spotlight-a-first-look-at-plan-offerings/s Landscape files for 2010-2025

Nearly two-thirds of SNPs (64%) are designed for people dually eligible for Medicare and Medicaid (D-SNPs). The number of D-SNPs has increased substantially since 2018 to 909 D-SNPs in 2025 (up from 851 D-SNAPs in 2024), suggesting insurers continue to be drawn to this high-need population. In 2024, 5.9 million Medicare beneficiaries are enrolled in D-SNPs.

The number of SNPs for people who require an institutional-level of care (I-SNPs) nearly doubled from 97 plans in 2018 to 189 plans in 2023, before dropping modestly to 173 plans in 2024 and 160 in 2025. I-SNPs may be attractive to insurers because they tend to have much lower marketing costs than other plan types since they are often the only available option for people who require an institutional level-of-care, such as those who have been in nursing homes for an extended period of time. In 2024, about 115,000 Medicare beneficiaries are enrolled in I-SNPs.

The number of SNPs offered for people with chronic conditions (C-SNPs) has nearly tripled since 2018, from 132 plans that year to 376 plans in 2025 (an increase of 67 plans since 2024). Most C-SNPs focus on people with diabetes, heart disease, or lung conditions, as has been the case since the inception of C-SNPs. For 2025, one firm is offering a C-SNP for people with dementia (different than the one firm offering one in 2024). Two firms are offering C-SNPs for people with mental health conditions (compared to no firms in 2024), and one firm is offering a C-SNP for people with HIV/AIDS, the same one as in 2024. Ten firms are offering C-SNPs for people with end-stage renal disease (up two from 2024). In 2024, 675,000 Medicare beneficiaries are enrolled in C-SNPs.

Medicare SNPs provide their members with all Medicare Part A (Hospital Insurance), Medicare Part B (Medical Insurance) services, and Medicare prescription drug coverage (Part D). Medicare SNPs were created to give certain groups better access to Medicare by enrolling in a plan designed to meet their unique needs.

An individual can join a Medicare SNP if they have Medicare Part A and Part B, live in the plan's service area, and meet one of the following requirements:

- They have one or more specific chronic or disabling conditions like diabetes, congestive heart failure, a mental health condition, or HIV/AIDS.
- Live in an institution (like a nursing home), or require nursing care at home; or
- Have both Medicare and Medicaid.

MA SNPs limit their membership to people in one of these groups or a subset of these groups. For example, an MA SNP may be designed to serve only members diagnosed with congestive heart failure. The plan would include access to a network of providers specializing in treating congestive heart failure. It would feature clinical case management programs designed to serve these special needs members with this condition. The plan's formulary would be designed to cover the drugs usually used to treat congestive heart failure. If they join this type of plan, they will get benefits tailored to their condition and coordinate their care through the MA SNP.

MA SNPs are approved by Medicare and run by private companies. When they join a Medicare SNP, enrollees will get their Medicare hospital and medical health care services through that plan, including Medicare prescription drug coverage.

Because they offer all health care services through a single plan, MA SNPs can help them manage their different services and providers. The plan can make it easier for them to follow their doctor's diet and prescription drug use. MA SNPs for people with both Medicare and Medicaid may also help them get help from the community and coordinate many of their Medicare and Medicaid services.

Like with other Medicare health plans, if they become members of a MA SNP, they may have to see providers who belong to the plan or use certain hospitals to get covered services. The MA SNP will still provide coverage for emergencies or urgently needed

care, even if they are out of the plan's service area. In most cases, they will need referrals to see specialists.

If they become a member of an MA SNP and they die and do not have both Medicare and Medicaid (or get other help from their state paying for their Medicare premiums), their exact costs will vary depending on the plan they chose. In general, they will pay the following:

- The monthly Medicare Part B premium.
- Any additional monthly premium the MA SNP charges above the Medicare Part B premium for Medicare Part A and B services.
- Any additional monthly premium the MA SNP charges for prescription drug benefits.
- Any additional monthly premium the MA SNP charges for extra benefits.
- Any plan deductible, coinsurance, or copayment amounts the MA SNP charges. For example, the plan may charge a set copayment amount, like $10 or $20, every time they see a doctor; and
- Their costs will also depend on the type of health care services they need, how often they get health care services, whether they follow the plan's rules, and what their plan charges for any extra benefits they may need. If they have Medicare and Medicaid, the MA SNP can't charge them higher cost-sharing amounts than they would pay in Original Medicare.

All MA SNPs include prescription drug coverage (Part D). Usually, members pay a copayment for their prescriptions. If the beneficiary has limited income and resources, they may be able to get Extra Help paying their prescription drug coverage costs. If they qualify, they may get their prescriptions filled and pay little or nothing out of pocket. There is no cost or obligation to apply for Extra Help, so anyone who thinks they might qualify should apply.

For more detailed information about MA SNP plans, go to: https://www.medicare.gov/pubs/pdf/11302.pdf and download the booklet "Your Guide to *Medicare Special Needs Plans (SNP).*"

Medicare Advantage Plan Offerings

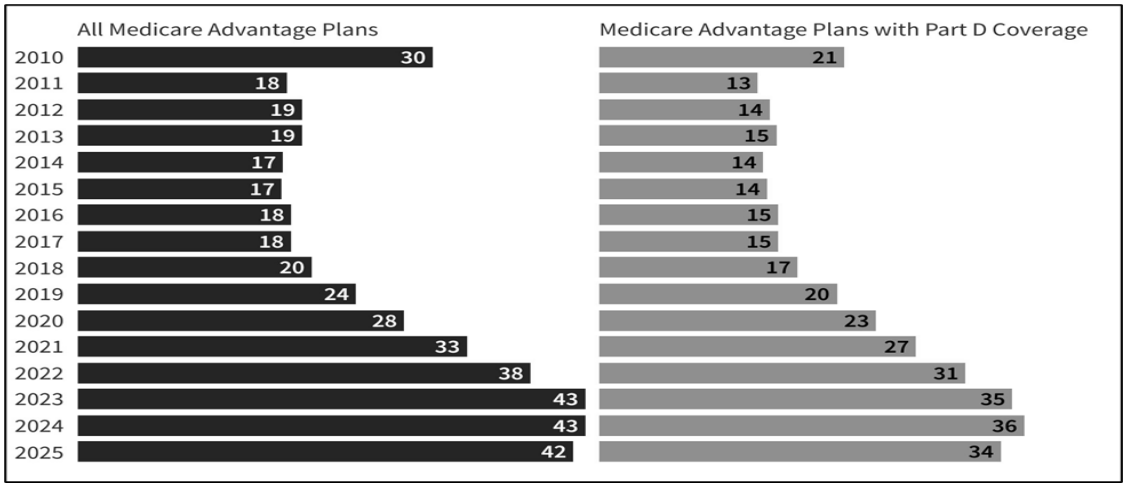
Over the last decade, Medicare Advantage, the private plan alternative to traditional Medicare, has taken on a prominent role in the Medicare program. In 2024, more than half (54%) of eligible Medicare beneficiaries – 32.8 million people out of 61.2 million Medicare beneficiaries with both Medicare Parts A and B – are enrolled in Medicare Advantage plans. Medicare Advantage plan enrollment is expected to see continued growth in 2025, with a projected 35.7 million enrollees.

Below is an overview of the Medicare Advantage plans that are available for 2025 and key trends over time.

Plan Offerings for 2025

For 2025, the average Medicare beneficiary will have access to 34 Medicare Advantage prescription drug (MA-PD) plans, just 2 fewer than the 36 in 2024 see (Figure 13.10). Across all plans for individual enrollment, including those with and without prescription drug coverage, the average beneficiary has 42 options in 2025, compared to 43 options in both 2023 and 2024. Since 2018, the number of plans available to the average beneficiary has doubled. These numbers exclude employer- or union-sponsored group plans, Special Needs Plans (SNPs), PACE plans, cost plans, and Medicare-Medicaid plans (MMPs) that are only available to select populations.

Figure 13.10
The Average Medicare Beneficiary Can Choose From 34 Medicare Advantage Prescription Drug Plan (MA_PD) plans in 2025, 2 Fewer Than the 36 in 2024

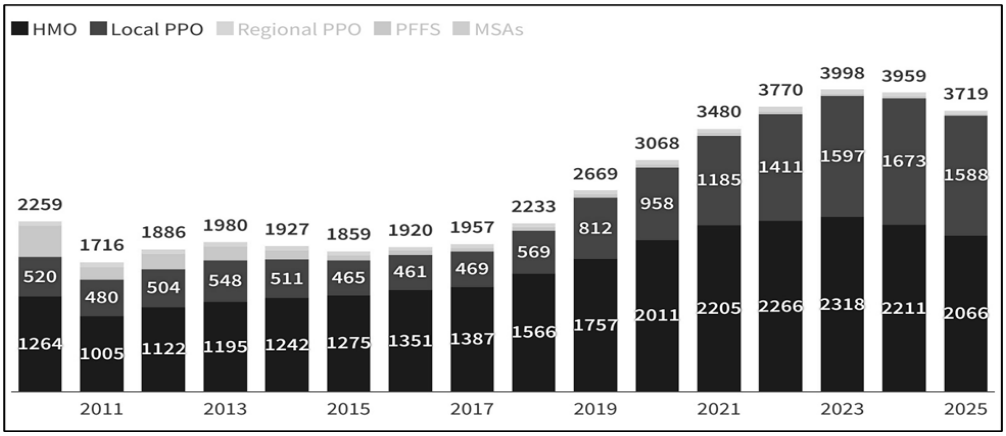


Note: Excludes SNPs, EGHPs, HCPPs, PACE plans, cost plans, and MMPs. Data on Connecticut is not included in 2024 and 2025 due to differences in FIPS codes in the CMS Landscape Files and CMS Medicare Enrollment Dashboard. KFF calculates the number of plans available to the average Medicare beneficiary based on enrollment in both Part A and B coverage during June of the prior year.
Source: KFF analysis of CMS Landscape Files, 2010-2025, Medicare Enrollment Dashboard, 2023-2024, and the CMS Chronic Conditions Data Warehouse Master Beneficiary Summary File (MBSF), 2009-2022.

Total Number of Plans

In total, 3,719 Medicare Advantage plans are available nationwide for individual enrollment in 2025 – a 6% decrease from the number of plans (240 fewer plans) offered in 2024 (see Figure 13.11).

Figure 13.11
HMOs Account for About Half of Medicare Advantage Plans Nationwide but Have Been Declining as a Share of the Total Since 2017 While Local PPOs are Rising as a Share of All Plans
Number of Medicare Advantage plans generally available by plan type, 2010-2025
(Number of Plans by Type)



Note: Excludes SNPs, EGHPs, HCPPs, PACE plans, cost plans and MMPs. Numbers may differ from previous publications in cases where the Landscape File for the year was updated after initial publication.
Source: KFF analysis of CMS Landscape files for 2010-2025.
www.kff.org/medicare/issue-brief/medicare-advantage-2025-spotlight-first-look/

HMOs account for more than half (56%) of all Medicare Advantage plans offered in 2025 but have declined as a share of all Medicare Advantage plans since 2017 (71% of plans), while during this period local PPOs rose as a share of all plans. During this period, the share of plans that are local PPOs increased from 24% to 43%. The share of regional PPOs has slowly declined from around 3% of plans offered in 2017 to 1% in 2025.

While many employers and unions also offer Medicare Advantage plans to their retirees, no information about these 2025 plan offerings is made available by CMS to the public during the Medicare open enrollment period. Employer and union plans are administered separately and may have enrollment periods that do not align with the Medicare open enrollment period.

Access to Medicare Advantage Plans, by Plan Type

As in recent years, virtually all Medicare beneficiaries (99.7%) have access to a Medicare Advantage plan as an alternative to traditional Medicare, including almost all beneficiaries in metropolitan areas (99.9%) and most beneficiaries in micropolitan (99.5%) and rural areas (98.4%). In micropolitan and rural counties, a smaller share of beneficiaries have access to HMOs (93% in micropolitan counties and 96% in rural counties versus over 99% in metropolitan counties) or local PPOs (98% in micropolitan counties and 96% in rural counties versus 99% in metropolitan counties), while a slightly

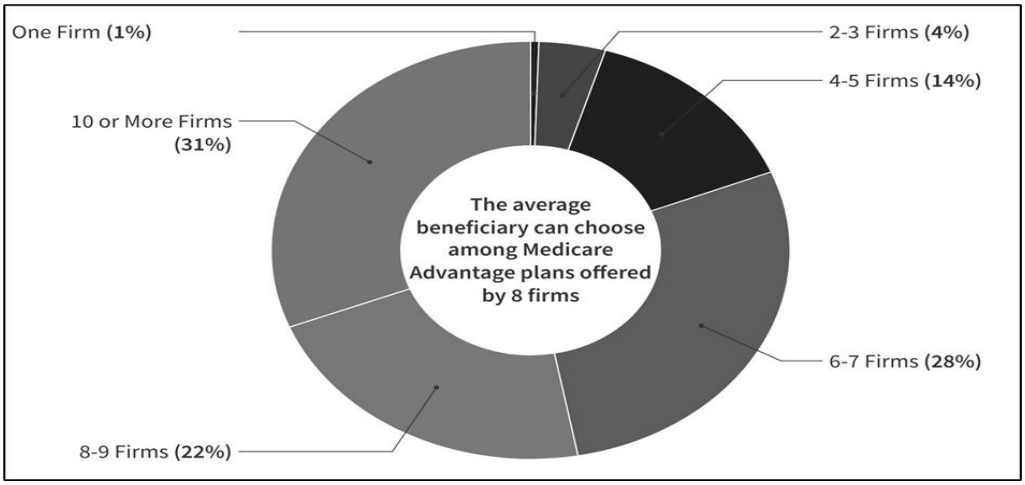
larger share of beneficiaries in non-metropolitan counties have access to regional PPOs (77% in both micropolitan and rural counties versus 73% in metropolitan counties).

Number of Firms

The average Medicare beneficiary can choose from plans offered by 8 firms in 2025, the same as in 2024. Despite most beneficiaries having access to plans operated by several different firms, enrollment is in plans operated by UnitedHealthcare and Humana, and together UnitedHealthcare and Humana account for nearly half (47%) of Medicare Advantage enrollment in 2024.

Figure 13.12 illustrates the Medicare Advantage enrollment by firm or affiliate.

Figure 13.12
Nearly One-Third (31%) of Beneficiaries Can Choose Among Medicare Advantage Plans Offered by 10 or More Firms in 2025



Note: Excludes SNPs, EGHPs, HCPPs, PACE plans, cost plans, and MMPs. In 2024, less than 0.3% of beneficiaries have access to no firms. **Source:** KFF analysis of CMS Landscape files for 2024 and June 2023 Medicare Enrollment Dashboard data.

In 2025, nearly one-third of beneficiaries (31%), in 169 counties, are able to choose from plans offered by 10 or more firms or other sponsors (a decline from 33% in 2024). In contrast, nearly 5 percent of beneficiaries live in a county where one to three firms offer Medicare Advantage plans (501 counties).

Further, in 126 counties, only one firm will offer Medicare Advantage plans in 2025. These are mostly rural counties with relatively few Medicare beneficiaries (less than 1 percent of total). In some of these counties, there were no firms offering Medicare Advantage in 2024, e.g., 5 counties in Idaho (Benewah, Clearwater, Custer, Lemhi, and Lewis). In contrast, Medicare beneficiaries in some counties had access to plans offered by two or three firms in 2024 but only one firm in 2025, such as people living in Coos County, Oregon.

MA Plans by Firm and County

UnitedHealthcare and Humana, the two firms with the most Medicare Advantage enrollees in 2024, have large footprints across the country, offering plans in most counties similar to 2024.

Both United healthcare and Humana offering plans (82% of counties) Humana and not United Healthcare (7% of counties); United Healthcare and not Humana (6% of counties). Neither insurer offering plans (5%).

Humana is offering plans in more counties than any other large Medicare Advantage insurer – 2,848 counties in 2025 – though that represents a decrease of 58 counties from 2024. Humana is exiting 70 counties, while entering 12 new counties. UnitedHealthcare is offering plans in 2,808 counties in 2025, an increase of 4 counties from 2024. UnitedHealthcare entered more counties (42 new counties) than it exited (38 counties).

Blue Cross Blue Shield Affiliates are offering plans in 2,639 counties in 2025, an increase of 35 counties from 2024. Blue Cross Blue Shield Affiliates are exiting 44 counties, but are entering 79 new counties. CVS is offering plans in 2,249 counties, an increase of 22 counties. CVS exited 65 counties but is entering 87 new counties.

Insurer decisions to exit some counties while entering new ones may suggest that local market factors impact insurer evaluations about their potential to attract enrollees and earn a profit.

Many Medicare Advantage firms are also offering more than one plan option in each county. More than half (58%) of Medicare beneficiaries live in a county (1,188) where at least one firm is offering 10 or more plans for individual enrollment. For example, in Cumberland County, Pennsylvania (the county with the most plan offerings – 87), four firms are offering 10 or more plans (Humana, Blue Cross Blue Shield Affiliates, UPMC Health Plan, and CVS Health). In 125 counties, two firms are offering 10 or more plans, and in 50 counties, three firms are offering 10 or more plans.

In 2025, Humana is increasing the number of plan options available in 631 counties, while decreasing the number of plan options in 1,192 counties. UnitedHealthcare is increasing the number of plans in 381 counties but decreasing plan offerings in 693 counties. Blue Cross Blue Shield Affiliates are increasing the number of plans options in 698 counties, while decreasing plan options in 630 counties. CVS Health is increasing the number of plan options in 667 counties, while decreasing them in 775 counties. This also suggests that insurers evaluate local markets when making decisions about the number of plans to offer and different county characteristics may make the market more or less attractive in a given year to a particular insurer.

Many Medicare Advantage firms are also offering more than one plan option in each county. In 1,136 counties (accounting for 50% of beneficiaries), at least one firm is offering 10 or more plans for individual enrollment. For example, in Bucks and Delaware counties in Pennsylvania, four firms are offering 10 or more plans (Humana, UnitedHealthcare, Blue Cross Blue Shield Affiliates, and CVS Health). In 137 counties, two firms are offering 10 or more plans, and in 63 counties, three firms are offering 10 or more plans.

Blue Cross Blue Shield Affiliates are offering the most plan options in a county, with 18 different plan options in seven counties. Humana is offering the next highest number of plan choices with 16 Medicare Advantage plans available in six counties, followed by CVS, which is offering 13 plan options in nine counties. Centene is offering 12 plans options in seven counties and United Healthcare is offering 11 plan options in three counties.

Plan Renewals and Terminations

In 2025, 5% of Medicare Advantage enrollees in MA-PDs or about 1.4 million people, are in a plan that has been terminated for the coming year and will not be automatically assigned to another plan. (This number includes people enrolled in SNPs but excludes people in MA-only plans or people with employer coverage). People in this group will be able to enroll in another Medicare Advantage plan if one is available or choose traditional Medicare. If they choose traditional Medicare, they will qualify for a special enrollment period for Medigap with guaranteed issue rights, meaning they can switch to traditional Medicare and will not be denied a Medigap policy due to a pre-existing condition.

Another 7% of Medicare Advantage enrollees in MA-PDs or about 1.8 million people, are in plans that have been affected by a consolidation. In this situation, some portion of this 1.8 million people will be moved into another plan under the same insurer automatically if the contract includes another plan of the same type (i.e., HMO or PPO) in the same county. (Some enrollees in consolidated renewal plans will not see changes in their plan because they were already in the plan that other enrollees are now being assigned to.) They may still enroll in another Medicare Advantage plan if one is available or choose traditional Medicare. However, they do not qualify for a special enrollment period under federal law for Medigap

New Market Entrants and Exits

In 2025, three firms (Healthy Mississippi, SECUR Health Plan and UCLA Health Medicare Advantage plan) entered the market for the first time, while eight firms exited the market. Healthy Mississippi has one new HMO plan available for general enrollment in Mississippi, while UCLA Health is offering two HMO plans available for general enrollment in California. SECUR Health Plan is offering two I-SNPs in Florida.

In the last few years, some firms have introduced plans that are either co-branded or are in partnership with another company. For example, in 2025, Alignment Health is offering three plans co-branded with Instacart in 7 counties in California and Nevada. These plans

will offer groceries to qualifying beneficiaries with chronic conditions. Alignment Health also partners with Walgreens and Rite Aid. Other companies with a partnership that are offering plans in 2025 include Select Health and Kroger and Humana and USAA though this is not an exhaustive list.

Eight firms that participated in the Medicare Advantage market in 2024 are not offering plans in 2025. Six of the firms had low enrollment in 2024 (around 10,000 or fewer enrollees per firm). Two of the firms had contracts taken over by other insurers.

Medicare Advantage Highlights for 2025

According to Kaiser Family Foundation, here are some highlights from their survey of 3,959 plans:

- Across all plans for individual enrollment, including those with and without prescription drug coverage, the average beneficiary has 42 options in 2025, compared to 43 options in both 2023 and 2024.
- HMOs account for more than half of all Medicare Advantage plans nationwide (56% in 2024) but are declining as a share of total, while local PPOs are rising as a share of all plans (42% in 2024).
- The number of D-SNPs (for dually eligible beneficiaries) has increased substantially over the past five years, nearly doubling from 465 dual SNPs in 2019 to 851 dual SNPs in 2024.
- More than one-third (37%) of Medicare beneficiaries live in a county where at least 60 percent of all Medicare beneficiaries are enrolled in Medicare Advantage plans.
- The average Medicare beneficiary has access to plans offered by 8 different firms in 2025, the same as in 2024, and an increase of 2 firms since 2018.
- Virtually all enrollees (99%) also have access to at least one zero premium plan that includes prescription drug coverage, consistent with recent years and substantially higher than the 84% in 2018.
- Humana and UnitedHealthcare plans are available in most counties in 2024 (90% and 87%, respectively). Most major insurers are also expanding into new counties, with CVS Health expanding in the largest number of counties in 2024.
- Most Medicare Advantage plans offer extra benefits, such as vision, dental and hearing as they have in previous years. Most Medicare Advantage plans do not offer Special Supplemental Benefits for the Chronically Ill, which are extra benefits available to a subset of a plan's enrollees, which are not primarily health related, and are specifically for chronically ill beneficiaries. However, more SNP plans than individual plans generally offer these benefits, particularly food and produce (60.0% in SNPs compared to 13.9% in individual plans).

MA Premiums

Medicare Advantage (MA) monthly premiums are expected to drop in price for 2025. Premiums are expected to decrease, on average, 6.75% next year, from $18.23 in 2024 to $17.00 in 2025, according the Centers for Medicare & Medicaid Services (CMS).

The figures above are based on projections the CMS received from Medicare Advantage providers and are weighted by enrollment figures. So, a beneficiary's premium could be different if they have a less popular plan. For example, using CMS 2024 data, the monthly average for all Medicare Advantage premiums in 2024 was $23.05.

About six in 10 people who now have a Medicare Advantage plan will pay $0 for premiums in 2025 if they stick with the same plan. And 83% of current beneficiaries who continue with their plans will have the same or a lower premium in 2025, according to the CMS.

In 2024, three quarters (75%) of enrollees in individual Medicare Advantage plans with prescription drug coverage pay no premium other than the Medicare Part B premium, which is a big selling point for beneficiaries, particularly those living on modest incomes and savings.

Most Medicare Advantage enrollees are in plans that offer supplemental benefits not covered by traditional Medicare, such as vision, hearing and dental. From 2023 to 2024, Medicare Advantage enrollees overall did not experience a significant loss in benefits despite concerns that changes in Medicare Advantage payment would lead to a drastic reduction in benefits or increase in premiums, though there were small declines in the share of enrollees in plans with access to some benefits from 2023 to 2024.

Nearly all Medicare Advantage enrollees (99%) are in plans that require prior authorization for some services, which is generally not used in traditional Medicare. Prior authorization is most often required for relatively expensive services, such as skilled nursing facility stays (99%), Part B drugs (98%), inpatient hospital stays (acute: 98%; psychiatric: 93%) and outpatient psychiatric services (82%) and is rarely required for preventive services (6%).

Maximum Out-of-Pocket Limits

MA plan's Maximum Out-of-Pocket (MOOP) threshold limits how much a beneficiary will spend on healthcare co-payments and co-insurance for eligible Medicare Part A (in-patient or hospitalization) and Medicare Part B (out-patient or doctor visit) coverage. A higher MOOP limit means the beneficiary will spend more out-of-pocket for their Medicare Part A and Medicare Part B covered services before reaching the annual maximum cost threshold.

Each year MOOP limits can change, and, starting back in 2021, the Centers for Medicare and Medicaid Services (CMS) began increasing the Maximum Out-of-Pocket limits for Medicare Advantage plan health benefit.

In 2025, Medicare Advantage plans can increase their Maximum Out-of-Pocket (MOOP) limit to $9,350, up from $8,850 in 2024. Based on these annual established MOOP limits, each Medicare Advantage plan then sets their plan's MOOP (explained below)—with the approval of CMS. These out-of-pocket limits apply to Part A and Part B services only, and do not apply to Part D prescription drug spending (TrOOP), for which there is a separate out of pocket threshold of $2,000 in 2025. Whether a plan has only an in-network cap or a cap for in-and out-of-network services depends on the type of plan. HMOs generally only cover services provided by in-network providers, whereas PPOs also cover services delivered by out-of-network providers but charge enrollees higher cost sharing for this care. The size of Medicare Advantage provider networks or physicians and hospitals vary greatly both across counties and across plans in the same county.

Note: If an MA beneficiary has high healthcare expenses, they may want to look for an increase in their MA plan's out-of-pocket spending limit. If their MOOP increases, they may wish to search for another MA plan with a lower MOOP limit ($3,850 or less). In short, the higher the MOOP limit, the higher your covered healthcare total expenses can be for the year. However, on a positive note, your Part A and Part B expenses will not exceed $9,350 for in-network Medicare cost-sharing (remember, this does not include Part D prescription drug expenses).

MA plan out-of-pocket costs that count towards the MOOP limit includes:

- Primary care or specialist copayments.
- Emergency room visit copayments.
- Your hospital per stay or per day deductible, or your per-day copayment for the first five or seven days of your hospital stay.
- Coinsurance for services such as x-ray and radiology services.
- Copayments for outpatient rehabilitation services.
- Coinsurance for a prosthetic device or durable medical equipment.
- Outpatient mental health or substance abuse visit copayments; and
- Outpatient hospital visits or ambulatory surgical center visit copayments.

About 9.26 million Medicare Advantage plan members will see an increase in their in-network 2025 MOOP. The MOOP increases for these people can range from $50 to $6,450.

Table 13.13 below shows the number of people affected by different ranges of 2025 MOOP increases.

Table 13.13
2025 Medicare Advantage Plans In-Network MOOP Limit Increases

Range Of MOOP Limit Increases	Number of Members Affected
$6,450	52,161
$5,000 to $6,449	15,099
$4,000 to $4,999	30,900
$3,000 to $3,999	301,886
$2,000 to $2,999	294,640
$1,000 to $1,999	1,953,529
$500 to $999	2,943,758
less than $500	3,653,034

Source: Q1Medicare.com;
https://q1medicare.com/news/Article.php?article=2025-medicare-advantage-plan-maximum-out-of-pocket&article_id=1050&category_id=18

In-Network vs. Out-of-Network MOOP

The MOOP limit is a cap on your out-of-pocket expenses and applies to in-network Medicare Part A and Medicare Part B eligible medical cost-sharing. Review the plan's documentation to see whether the out-of-network healthcare costs are included in the MOOP. For example, you may find that local and regional PPO Medica Advantage plans can have a combined maximum MOOP of up to $14,000 (for in-network and out-of-network coverage) and local HMOs may not include out-of-network healthcare costs in the annual MOOP limit.

The 2025 Medicare Advantage MOOPs range from $0 to $9,350–and often Medicare Advantage plans with a MOOP of $0 are MSAs or Cost plans. In 2023, Medicare renamed the Voluntary MOOP to "Lower" MOOP and added a third category "Intermediate" MOOP limit between the two MOOP –so the MOOP limits are: "Lower", "Intermediate", and "Mandatory."

The Lower, Intermediate, and Mandatory MOOP limits are set by the Centers for Medicare and Medicaid Services (CMS). Per CMS, the Mandatory MOOP amount represents approximately the 95th percentile of projected beneficiary out-of-pocket spending. In other words, five percent of Original Medicare beneficiaries are expected to incur approximately $9,350 or more in Parts A and B deductibles, copayments, and coinsurance. The Lower MOOP amount of $4,150 represents approximately the 85th percentile of projected Original Medicare out-of-pocket spending. Intermediate MOOP is set at the numeric midpoint of the Mandatory and Lower MOOP limits.

Table 13.14 shows a comparison of the number of plans falling into the three established MOOP ranges.

Table 13.14
Medicare Advantage Plans per CMS Defined MOOP Limits

2025			2024		
MOOP Limit Range	Nbr of Plans	% of Plans	MOOP Limit Range	Nbr of Plans	% of Plans
Lower $0 to $4,150	1,708	30%	Lower $0 to $4,150	1,288	29%
Intermediate $4,151 to $6,750	2,182	39%	Intermediate $4,151 to $6,750	2055	46%
Mandatory $6,751 to $9,350	1,754	31%	Mandatory $6,751 to $9,350	1,057	24%

Source: Q1Medicare.com;
https://q1medicare.com/news/Article.php?article=2025-medicare-advantage-plan-maximum-out-of-pocket&article_id=1050&category_id=18

According to Q1Medicare.com, they found that across all 2025 MA plans, 1,421 plans increased their MOOP, 1,563 plans kept the same MOOP as last year, and 421 plans reduced the plans MOOP limit. When MOOP is evaluated across all MA plans (excluding MMPs and SNPs which do not have a MOOP), there is a slight increase in the average 2025 MOOP limit. The 2025 average MOOP is around $5,840 as compared to $5,064 in 2024.

Table 13.15 below illustrates some of the more frequently occurring 2024 MOOP limits across all types of Medicare Advantage plans. Note that 70% of 2024 MA plans have a MOOP over the $3,850 "Lower" MOOP as compared to 74% over the 2023 "Lower" MOOP of $3,650.

Table 13.15
Top 2025 MOOP Limits for Medicare Advantage Plan

	Number of Medicare Advantage Plans (MA & MAPD)					
MOOP limits	**2025**	**2024**	**Change '24 to '25**	**Percent**	**2023**	**2022**
$9,350	1,079	0	0	0	0	0
$6,700	289	231	58	25%	520	520
$4,900	230	231	-1	0%	210	207
$6,750	229	11	218	1,982%	0	0
$5,900	209	222	-13	-6%	223	250
$3,400	205	185	20	11%	207	267
$5,500	181	187	-6	-6%	223	250
$3,900	178	158	20	-11%	267	267

$4,500	161	205	-44	-21%	206	203
$5,000	133	139	-6	-4%	149	134
$4,150	116	76	40	53%	5	1
$2,900	100	113	-13	-12%	122	96
$7,900	89	34	55	162%	20	
$7,550	81	193	-112	-58%	318	513
2025 Lower, Intermediate, and Mandatory MOOP Limits						
$4,150	116	76	40	53%	5	1
$6,750	229	11	218	1,982%	0	0
$9,350	1,079	0	1,079	0%	0	0

Source: Q1Medicare.com; https://q1medicare.com/news/Article.php?article=2025-medicare-advantage-plan-maximum-out-of-pocket&article_id=1050&category_id=18

MA plans may set their MOOP threshold as any amount within the ranges shown in Table 13.16 below. As an example, HMO plans can set their plan's MOOP as high as $9,350; however, an HMO plan that sets MOOP within the lower ($0 - $3,850) or intermediate ($3,851 - $6,350) range is granted greater flexibility for individual service category cost-sharing.

The Summary of Benefits and Evidence of Coverage insurance plan will provide detailed information about the actual deductibles, copayments, coinsurance, and other out-of-pocket costs applicable to services covered under the MA plan.

It's important to note that any monthly premium an enrollee pays for MA coverage does not count towards their plan's out-of-pocket maximum. Additionally, any costs paid for outpatient prescription drug coverage (Part D) do not apply to the out-of-pocket maximum. The MA out-of-pocket maximum only includes the combined cost for copayments, coinsurance, and other costs paid for medical services.

MA plans with managed care networks may have different out-of-pocket maximums based on whether the services are provided in-network or out-of-network. This is especially true for Preferred Provider Networks (PPO) and Health Maintenance Organization–Point of Service Networks (HMO-POS) plans. It's important to note that any monthly premium an enrollee pays for MA coverage does not count towards their plan's out-of-pocket maximum. Additionally, any costs paid for outpatient prescription drug coverage (Part D) do not apply to the out-of-pocket maximum. The MA out-of-pocket maximum only includes the combined cost for copayments, coinsurance, and other costs paid for medical services.

MA plans with managed care networks may have different out-of-pocket maximums based on whether the services are provided in-network or out-of-network. This is especially true for Preferred Provider Networks (PPO) and Health Maintenance Organization–Point of Service Networks (HMO-POS) plans.

Table 13.16
2025 Lower, Intermediate and Mandatory
MOOP Range by Type of Medicare Advantage Plan

Plan Type	Lower (Voluntary)	Intermediate	Mandatory
HMO	$0 - $4,150	$4,151 - $6,750	$6,751 - $9,350
HMO POS	$0 - $4,150 In-network	$4,151 - $6,750	$6,751 - $9,350 In-network
Local PPO	$0 - $4,150 In-network and $0 - $6,200 Combined	$4,151 - $6,750 In-network and $4,151 - $9,750 Combined	$6,751 - $9,350 In-network and $6,751 - $14,000 Combined
Regional PPO	$0 - $4,150 In-network and $0 - $6,200 Combined	$4,151 - $6,750 In-network and $4,151 - $10,100 Combined	$6,751 - $9,350 In-network and $6,751 - $14,000 Combined
PFFS (full network)	$0 - $4,150 Combined	$4,151 - $6,750	$6,751 - $9,350 Combined
PFFS (partial network)	$0 - $4,150 Combined	$4,151 - $6,750	$6,751 - $9,350 Combined
PFFS (non-network)	$0 - $4,150	$4,151 - $6,350	$6,751 - $9,350

Source: Q1Medicare.com;
https://q1medicare.com/news/Article.php?article=2025-medicare-advantage-plan-maximum-out-of-pocket&article_id=1050&category_id=18

The above list is a sample of out-of-pocket expenses that may be incurred under an MA plan.

MA Plans Extra (Supplemental) Benefits

Medicare Advantage plans may provide extra ("supplemental") benefits that are not offered in traditional Medicare, are considered "primarily health-related," and can use rebate dollars (including bonus payments) to help cover the cost of extra benefits. Beginning in 2019, CMS expanded the definition of "primarily health-related" to allow MA plans to offer additional supplemental benefits. MA plans may also restrict the availability of these extra benefits to certain subgroups of beneficiaries, such as those with diabetes or congestive heart failure, making different benefits available to different enrollees.

Supplemental Benefits in Plans for General Enrollment

Medicare Advantage plans may provide extra benefits that are not available in traditional Medicare, are considered "primarily health related," and can use rebate dollars (including bonus payments) to help cover the cost of these extra benefits. Beginning in 2019, CMS expanded the definition of "primarily health related" to allow Medicare Advantage plans

to offer additional supplemental benefits. Medicare Advantage plans may also restrict the availability of these extra benefits to certain subgroups of beneficiaries, such as those with diabetes or congestive heart failure, making different benefits available to different enrollees.

Availability of Extra Benefits in Plans for General Enrollment

In 2025, 97% or more individual plans offer some vision, dental or hearing benefits, similar to 2024 (see Table 13.17. Though these benefits are widely available, the scope of coverage for these services varies. For example, dental benefits may include cleanings and preventive care or more comprehensive coverage and often is subject to an annual dollar cap on the amount covered by the plan. From year to year, plans may change the parameters of this coverage, such as increasing or decreasing annual maximums the plan will pay toward the benefit or adjusting cost sharing for services. There is not yet data available about utilization of these benefits associated costs, so it is not clear the extent to which supplemental benefits are used by enrollees.

As of 2020, Medicare Advantage plans have been allowed to include telehealth benefits as part of the basic benefit package – beyond what was allowed under traditional Medicare prior to the COVID-19 public health emergency, which was extended to December 2024. Therefore, these benefits are not included in the figure above because their cost is not covered by either rebates or supplemental premiums. Medicare Advantage plans may also offer supplemental telehealth benefits via remote access technologies and/or telemonitoring services, which can be used for those services that do not meet the requirements for coverage under traditional Medicare or the requirements for the telehealth benefits as part of the basic benefit package (such as the requirement of being covered by Medicare Part B when provided in-person). In 2025, 53% of plans are offering remote access technologies, a decline from 74% in 2024. A similar share of plans are offering telemonitoring services (2% in 2025 vs 3% in 2024).

Some benefits are being offered by a smaller share of plans in 2025 than in 2024. For example, 73% of plans are offering an allowance for over-the-counter items (vs. 85% in 2024), while 65% are offering meal benefits (vs. 72% in 2024), and 30% are offering transportation benefits for medical needs (vs. 36% in 2024). A similar share of plans is offering acupuncture (32% in 2025 vs. 34% in 2024), bathroom safety devices (24% in 2025 vs 22% in 2024), and support for caregivers of enrollees (5% in 2025 and 2024). A smaller share of plans are offering in-home support services (6% in 2025 vs 9% in 2024). This is not an exhaustive list of extra benefits that plans offer, and plans may provide other services such as home-based palliative care, therapeutic massage, and adult day health services, among others.

Virtually all Medicare beneficiaries live in a county where at least one Medicare Advantage plan available for general enrollment (excluding SNPs) has some extra benefits not covered by traditional Medicare, with over 99% having access to at least one or more plans with dental, fitness, vision, and hearing benefits for 2025, the same as in 2024. The vast majority of beneficiaries also have access to one or more plans that offer an allowance for over-the-counter items (over 99%), a meal benefit (over 99%), remote

access technologies (99%), acupuncture (98%), bathroom safety devices (96%), transportation assistance (94%) but fewer have access to one or more plans that offer in-home support services (60%), caregiver support (41%), or telemonitoring services (16%). (Connecticut is not included in these estimates – see methods for more details.)

Table 13.17
The Share of Individual MA Plans Offering Supplemental Benefits, 2025

Eye exams and/or eyeglasses	99%
Dental	98%
Hearing exams and/or aids	97%
Fitness	95%
Over the counter Benefits	73%
Meal Benefit	65%
Remote Access Technologies	53%
Part B Rebate	32%
Acupuncture	32%
Transportation	30%
Bathroom Safety Devices	24%
In-Home Support Services	6%
Support for Caregivers	5%
Telemonitoring Services	2%

Note: Vision includes eye exams and/or eyeglasses. Hearing includes hearing exams and/or aids. Dental includes all plans that provide dental benefits, including those that provide preventive benefits only, such as cleanings. Individual plans are plans open for general enrollment and exclude EGHPs and SNPs.
Source: KFF analysis of CMS Landscape and Benefit files for 2020-2025.

Access to Medicare Advantage Plans with Extra Benefits

Virtually all Medicare beneficiaries live in a county where at least one Medicare Advantage plan available for general enrollment (excluding SNPs) has some extra benefits not covered by traditional Medicare, with over 99% having access to at least one or more plans with dental, fitness, vision, and hearing benefits for 2025, the same as in 2024. The vast majority of beneficiaries also have access to one or more plans that offer an allowance for over-the-counter items (over 99%), a meal benefit (over 99%), remote access technologies (99%), acupuncture (98%), bathroom safety devices (96%), transportation assistance (94%) but fewer have access to one or more plans that offer in-home support services (60%), caregiver support (41%), or telemonitoring services (16%).

Availability of Extra Benefits in Special Needs Plans

SNPs are designed to serve a disproportionately high-need population, and a somewhat larger percentage of SNPs than plans for other Medicare beneficiaries provide their enrollees over-the-counter benefits (92%; similar to 2024 – 94%), transportation benefits for medical needs (81%; a decline from 88% in 2024), meals (73%, similar to 2024 –

75%), bathroom safety devices (54%; up from 34% in 2024), and in-home support services (17%; down from 25% in 2024). Compared to individual plans, a smaller share of SNPs offer fitness benefits (83%, similar to 2024 – 84%), remote access technologies (50%; a decline from 66% in 2024), and the Part B rebate (29%; up from 7% in 2024). Similar to plans available for individual enrollment, a relatively small share of SNPs offer support for caregivers (5%) or telemonitoring services (2%).

Availability of Special Supplemental Benefits for the Chronically Ill (SSBCI)

Beginning in 2020, Medicare Advantage plans have also been able to offer extra benefits to a subset of a plan's enrollees, that are not primarily health related and are specifically for chronically ill beneficiaries, known as Special Supplemental Benefits for the Chronically Ill (SSBCI). In addition, Medicare Advantage plans participating in the Value-Based Insurance Design Model may also offer these non-primarily health related supplemental benefits to their enrollees, but can use different eligibility criteria than required for SSBCI, including offering them based on an enrollee's socioeconomic status (e.g., LIS Eligibility) or whether the enrollee lives in an underserved area.

Most individual and SNP Medicare Advantage plans still do not offer these benefits, though more SNP plans generally offer these benefits, particularly food and produce. SSBCI benefits offered in 2025 include food and produce (15%% for individual plans and 84% for SNPs), general supports for living (e.g., housing, utilities) (11% in individual plans and 67% for SNPs), transportation for non-medical needs (8% for individual plans and 46% for SNPs), and pest control (3% for individual plans and 23% for SNPs)

Medicare Plan Finder

The Centers for Medicare & Medicaid Services (CMS) has developed a modernized and redesigned Medicare Plan Finder. The Medicare Plan Finder, the most used tool on Medicare.gov, allows users to shop and compare Medicare Advantage (and Part D plans). The updated Medicare Plan Finder provides a mobile-friendly and easy-to-read design to help individuals learn about different options and select coverage that best meets their health needs. The new Plan Finder walks users through the Medicare Advantage and Part D enrollment process from start to finish and allows people to view and compare many of the supplemental benefits that Medicare Advantage plans offer. You can visit the website at: : https://www.medicare.gov/plan-compare/#/?lang=en&year=2023

MA Plan Star Quality Ratings System

The Centers for Medicare & Medicaid Services (CMS) publishes the Medicare Advantage (Medicare Part C) and Medicare Part D Star Ratings each year to measure the quality of health and drug services received by consumers enrolled in Medicare Advantage (MA) and Prescription Drug Plans (PDPs or Part D plans). The Star Ratings

system helps Medicare consumers compare the quality of Medicare health and drug plans being offered so they are empowered to make the best health care decisions for them. An important component of this effort is to provide Medicare consumers and their caregivers with meaningful information about quality alongside information about benefits and costs to assist them in being informed and active health care consumers.

All plans are rated on a 1 to 5-star scale, with 1 star representing poor performance, 3 stars representing average performance, and 5 stars representing excellent performance. CMS assigns quality ratings at the contract level rather than for each individual plan, meaning that each plan covered under the same contract receives the same quality rating (and most contracts cover multiple plans of the same type). Since 2012, MA plans with 4 or more stars and plans without ratings have received bonus payments based on quality ratings. Plans with higher star ratings are eligible for significantly higher rebates. Beneficiaries can enroll in a plan with 5 stars at any time during the year, not just during the annual open enrollment period. CMS may terminate Medicare Advantage Part C and Part D plans that receive less than 3-stars for 3 consecutive years.

For 2025 Centers for Medicare & Medicaid Services (CMS) increased many measure-level cut points from the 2024 Star Ratings, requiring MAOs to achieve higher performance on these measures to receive a four or higher Star Rating. The results, Significant attention is being given to the notable overall industry decline in Star Ratings, in 2025 the average star rating declined from 4.37 in 2022 to 3.92 in 2025 (see Table 13.18). Specifically, only seven Medicare Advantage (MA) plans received an overall 5-Star Rating in 2025, compared with 38 in 2024. Only 40 percent of MA prescription drug plans achieved a score of four or five Stars versus 43 percent in 2024.

Figure 13.18
Decline in Star Rating, 2022-2025

Year	Average Rating
2022	4.37
2023	4.14
2024	4.07
2025	3.92

Source: Health Management Associates (MMA)
The release of 2025 Medicare Advantage Star ratings and improving future rating cycle performance

The ratings significantly influence the financial and operational effectiveness of each MAO, directly affecting plan reimbursement and ability to enhance benefits. The 2025 Star Ratings will impact 2026 MA quality bonus payments. Health plans that earn four or more Stars are eligible for quality bonus payments and greater rebate percentage the following year. Plans may reinvest payments to make plan products more attractive to beneficiaries and emphasize a higher rating in their marketing efforts.

Medicare Advantage Quality Bonus Program

To encourage Medicare Advantage plans to compete for enrollees based on quality, the Affordable Care Act (ACA) established a quality bonus program that increases payments to plans based on a five-star rating system. Plans may, but are not required to, use the additional payments to cover the cost of supplemental benefits, including reduced cost sharing, services not covered by traditional Medicare (e.g., vision, hearing and dental), and rebates against the Part B and/or Part D premiums.

Background on the MA Quality Bonus Program

A key feature of the quality bonus program is the star rating system (discussed above). Star ratings are used to determine two parts of a Medicare Advantage plan's payment:

- Whether the plan is eligible for a bonus, and
- The portion of the difference between the benchmark and the plan's bid that is paid to the plan.

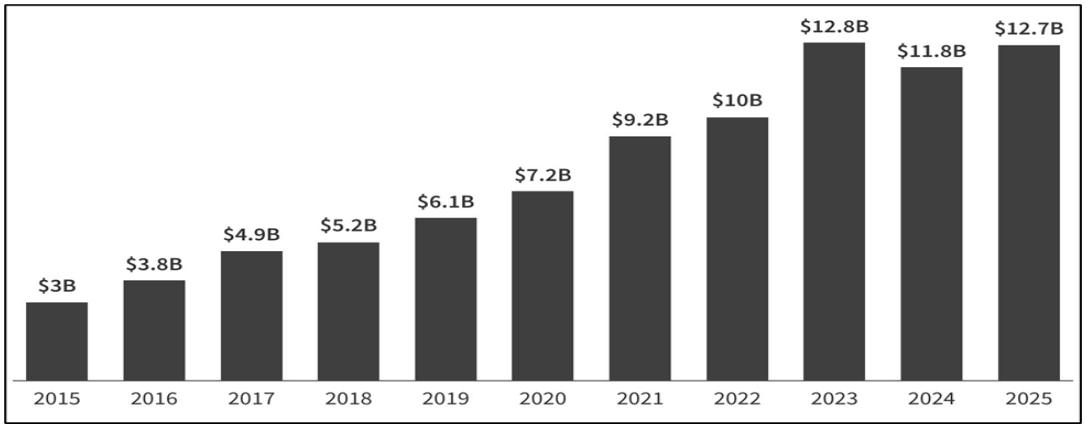
The benchmark is the maximum amount the federal government will pay for a Medicare Advantage enrollee and is a percentage of estimated spending in traditional Medicare in the same county, ranging from 95 percent in high-cost counties to 115 percent is low-cost counties. The bid is the plan's estimated cost for providing services covered under Medicare Parts A and B.

Since 2015, plans that receive at least four (out of five) stars have increased their benchmark. For most plans in bonus status, the benchmark is increased by five percentage points. Plans in "double bonus" counties – defined as urban counties with low traditional Medicare spending and historically high Medicare Advantage enrollment—have their benchmark increased by 10 percentage points. In addition, the benchmarks for plans without ratings due to low enrollment or being too new are increased by 3.5 percentage points. The benchmarks are capped and cannot be higher than they would have been prior to the ACA. This can result in plans that are eligible under the quality bonus program receiving a smaller increase to their benchmark, or in some cases, no increase at all.

The Quality Bonus Program in 2025

Estimated bonus payments to Medicare Advantage plans will total at least $12.7 billion in 2025, similar to 2023. Bonus payment spending had decreased slightly in 2024 following a decline in star rating after the expiration of COVID-19 pandemic-era policies. Those policies prevented individual measures that go into calculating the star ratings from declining between 2021 and 2022 and temporarily increased star ratings for certain plans. Bonus payments have increased sharply since the program started, more than quadrupling from $3.0 billion in 2015 to $12.7 billion in 2025 (Figure 13.19). The total spending on the quality bonus program is less than 2.5% of the projected payments to Medicare Advantage plans in 2025, ($540 billion),

Figure 13.19
Total Spending on Medicare Advantage Plan Bonuses Will Increase in 2025 to $12.7 Billion



Source: KFF analysis of CMS Enrollment and Plan Quality and Performance Ratings Files, 2015-2025. https://www.kff.org/medicare/issue-brief/medicare-advantage-quality-bonus-payments/

Medicare spending on bonus payments has grown faster than enrollment in Medicare Advantage, which has doubled since 2015. This spending comes at a time when the Medicare program is facing growing fiscal pressure. Medicare Advantage benchmarks (and corresponding spending) have grown faster than traditional Medicare spending in part because of the increase in bonus payments.

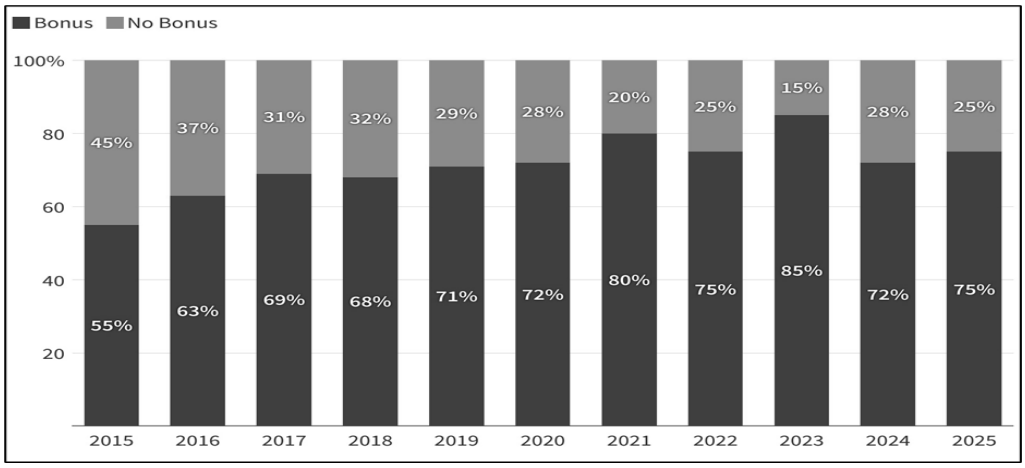
These estimates are a lower bound because bonus payments are risk adjusted, which is likely to increase bonus payments. The estimates also do not include additional spending that results if plans increase their bids when their benchmark is higher because of being in bonus status. For example, a plan might increase its bid to increase payments to providers, add more expensive providers to its network, or retain a larger amount as profit, provided they meet medical loss ratio requirements.

The distribution of bonus spending across plan types is similar to the distribution of enrollment in 2025, though employer plans comprise a slightly larger share of bonus spending than enrollment. Individual plans account for 61% ($7.8 billion) of bonus spending and 62% of enrollment, employer plans account for 20% ($2.5 billion) of bonus spending and 17% of enrollment, and special needs plans account for 19% ($2.4 billion) of bonus spending and 21% of enrollment in 2025.

Enrollment in Plans in Bonus Status

In 2025, nearly 26 million people, or 75% of Medicare Advantage enrollees, are in plans that are receiving bonuses. That compares to just under 9 million people (55%) in 2015 (see Figure 13.20). The share of enrollees in plans that receive bonus payments in 2025 is slightly higher than the previous year (72%).

Figure 13.20
Most MA Enrollees (75%) Are in Plans That Receive Bonus Payments in 2025



Note: Includes all individual, employer, and special needs plans. Bonus status is based on a plan's star rating for the previous year.
Source: KFF Analysis of CMS Enrollment and Plan Quality and Performance Ratings Files, 2015-2025.
https://www.kff.org/medicare/issue-brief/medicare-advantage-quality-bonus-payments/

In 2025, Medicare Advantage plans receive an average annual bonus of $372 per enrollee, more than double the $184 average bonus per enrollee in 2015. Average bonuses in group employer- and union-sponsored plans have consistently been higher than for other plans. The average bonus per enrollee in a group employer- or union-sponsored Medicare Advantage plan is $438 in 2025, compared to $368 for individual plans and $332 for special needs plans (SNPs).

Medicare Advantage Plan Enrollment Periods

Enrolling in an MA plan is optional. However, the beneficiary must be entitled to both Medicare Parts A and B. There are specific times when a beneficiary can sign up for Medicare Advantage (Part C) or amend the coverage they already have:

- Initial Enrollment Period (IEP).
- Fall Open Enrollment Period (or Annual Coordinated Election Period–AEP).
- Open Enrollment Period; and
- Special Enrollment Period.

Initial Enrollment Period

The Initial Enrollment Period (IEP) is the period when a beneficiary first becomes eligible for Medicare or when they turn 65, during their Initial Enrollment Period.

Table 13.21 describes the Initial Enrollment Period and the elections a Medicare enrollee can choose from.

Table 13.21
Initial Enrollment Period

If this describes your client…	- They can…	At this time…
Newly eligible for Medicare because they turned 65.	Sign up for an MA plan.	During the 7-month period that starts 3 months before the month they turn 65, includes the month they turn 65, and ends 3 months after the month they turn 65.
Newly eligible for Medicare because they are disabled (under age 65). Note: This doesn't apply if they have ESRD.	Sign up for an MA plan.	During the 7-month period that starts 3 months before their 25th month of disability and ends 3 months after their 25th month of disability.
They are already eligible for Medicare because of a disability and turning 65.	Sign up for an MA plan; Switch from a current MA plan to another plan; or Drop a MA plan completely.	During the 7-month period that starts 3 months before the month they turn 65, includes the month they turn 65, and ends 3 months after the month they turn 65. If you sign up for an MA plan during this time, they can drop that plan at any time during the next 12 months and go back to Original Medicare.

Fall Open Enrollment Period

For 2024, open enrollment will run from October 15, 2023, to December 7, 2023. Coverage begins January 1, 2024. Table 13.22 describes the Fall Open enrollment period and the elections an MA beneficiary can choose.

Table 13.22
MA Fall Open (Annual) Enrollment Period

Enrollment Period	What the Enrollee Can Do
Fall Open (Annual) Enrollment Period October 15th through December 7 (Coverage begins January 1)	• Switch from Original Medicare to a Medicare Advantage (MA) Plan, or vice versa. • Switch from one MA Plan to another. • Switch from one MA Plan to another Medicare Advantage Plan. • Switch from a MA Plan that doesn't offer drug coverage to a MA Plan that offers drug coverage; and • Switch from an MA Plan that offers drug coverage to a Medicare Advantage Plan that doesn't offer drug coverage.

Annual Open Enrollment Period

The 21st Century Cures Act, Section 17005, which was signed into law by President Barack Obama on December 13, 2016, expanded the existing MA Disenrollment Period (MADP) that took place from January 1 through February and expanded the timeframe of the window (from one and a half months to three months), and allows people to switch from one MA plan to another.

Table 13.23 describes the MA Open Enrollment period and the elections an MA beneficiary can choose.

Table 13.23
MA Open Enrollment Period

Enrollment Period	What the Enrollee Can Do
MA Open Enrollment Period January 1–March 31 (Coverage begins on the first day of the month following enrollment.)	• If enrolled in a MA Plan, enrollees can leave the plan, return to Original Medicare, and buy a Part D PDP to supplement their Original Medicare. Original Medicare coverage will begin the first day of the following month; and If enrolled in a MA plan, enrollees will have the option to switch to a different MA plan during this time. Only one switch during this time frame is allowed each year.

Special Enrollment Period

Table 13.24 describes the Special Enrollment Periods and the elections an MA beneficiary may choose.

Table 13.24
Special Enrollment Periods

Changes where Enrollee lives		
If this describes your client	**They can**	**At this time**
Moved to a new address that isn't in their plan's service area.	Switch to a new MA plan.	If the plan is informed before the move, the chance to switch plans begins the month before the month of the move and continues for 2 full months after the move. If the plan is informed after the move, the chance to switch plans begins the month the plan is informed, plus 2 more full months.
Moved to a new address that's still in the plan's service area, but there are new plan options in the new location.		
Moves back to the United States after living outside the country.	Join a MA plan.	The chance to join lasts for 2 full months after the month of the move back to the U.S.
Just moved into, currently live in, or just moved out of	Join a MA plan. Switch from a current plan to another MA	The chance to join, switch, or drop coverage lasts as long as they live

an institution (such as a skilled nursing facility or long-term care hospital).	plan. Drop a MA plan and return to Original Medicare.	in the institution and for 2 full months after the month they move out of the institution.
Released from jail.	Join a MA plan.	The chance to join lasts for 2 full months after the month released from jail.
No longer eligible for Medicaid.	Join a MA plan: Switch from a current plan to another MA plan. Drop an MA plan and return to Original Medicare. Drop the Medicare prescription drug coverage.	The chance to change lasts for 2 full months after the month they find out they're no longer eligible for Medicaid.
Leaves coverage from an employer or union (including COBRA coverage).	Join a MA plan.	The chance to join lasts for 2 full months after the month the coverage ends.
Changes where Enrollee lives		
If this describes your client	**They can**	**At this time**
Involuntarily loses other drug coverage that is as good as Medicare drug coverage (creditable coverage), or the other coverage changes and is no longer creditable.	Join a MA plan with drug coverage.	The chances to join lasts for 2 full months after the month of losing creditable coverage or are notified of the loss of creditable coverage, whichever is later.
Drops coverage in a Program of All-Inclusive Care for the Elderly (PACE) plan.	Join a MA plan.	The chance to join lasts for 2 full months after the month PACE plan is dropped.
Chance to get other coverage		
Chance to enroll in other coverage offered by an employer or union.	Drop the current MA plan to enroll in the private plan offered by an employer or union.	Whenever the employer or union allows changes in the plan.
Enrolling in other drug coverage as good as Medicare prescription drug coverage (such as TRICARE or VA coverage).	Drop the current MA plan with drug coverage or the Medicare Prescription Drug Plan.	Anytime.
Enrolls in a Program of All-Inclusive Care for the Elderly (PACE) plan.	Drop the current MA plan.	Anytime.
Lives in the service area of one or more MA plan or Medicare Prescription Drug Plans with an overall quality rating of 5 stars.	Join an MA plan with an overall quality rating of 5 stars.	One time during the year for which the plan to join has the overall quality rating of 5 stars.
Changes in the contract with Medicare		
If this describes your client	**Then they can**	**At this time**
Medicare takes an official action (called a "sanction") because of a problem with the plan that affects enrollee.	Switch from the MA plan to another plan.	The chance to switch is determined by Medicare on a case-by-case basis.
Plan's contract ends (terminates) during the contract year.	Switch from the MA plan to another plan.	The chance to switch starts 2 months before and ends 1 full month after the contract ends.

Changes due to other special situations		
Eligible for both Medicare and Medicaid.	Join, switch, or drop MA coverage.	Anytime.
Enrolled in a State Pharmaceutical Assistance Program (SPAP) or lose SPAP eligibility.	Join either a MA plan with prescription drug coverage.	Once during the calendar year.
They dropped a Medigap policy the first time they joined a Medicare Advantage Plan.	Drop the MA Plan and enroll in Original Medicare. They will have special rights to buy a Medigap policy.	The chance to drop the MA Plan lasts for 12 months after they join the Medicare Advantage Plan for the first time.
It has a severe or disabling condition, and there is a Medicare Chronic Care Special Needs Plan (SNP) available that serves people with this condition.	Join a Medicare Chronic Care SNP.	They can join anytime, but once joined, the chance to make changes using this SEP ends.
Enrolled in a Special Needs Plan (SNP) and no longer has a condition that qualifies as a special need that the plan serves.	Switch from the SNP to a MA Plan.	They can choose a new plan starting from the time special needs status is lost, up to 3 months after the SNP grace period ends.
Joined a plan, or chose not to join a plan, due to an error by a federal employee.	Join a MA Plan with drug coverage. Switch from the current plan to another MA Plan with drug coverage. Drop the MA Plan with drug coverage and return to Original Medicare.	The chance to change coverage lasts for 2 full months after the month a notice of the error from Medicare is received.

Medicare Complaints

They're the TV stars of a bygone era, a heroic quarterback, a starship captain, and a sitcom sensation.

Joe Namath, William Shatner. and Jimmie J.J. Walker have been back on TV screens in recent years, working as pitchmen and urging older viewers to call in to see if they are eligible for extra Medicare benefits and bigger Social Security payments.

Consumer watchdogs say the commercials are grossly misleading, making promises the company behind them often can't deliver. The ads – and similar marketing pitches – have coincided with a spike in complaints about Medicare Advantage marketing, which surged 165% last year.

Misleading TV ads are just one of many risks Medicare beneficiaries face during the Open Enrollment Period. There's a separate threat from would-be fraudsters who try to take advantage of the Open Enrollment Period that runs from October 15th through Dec. 7 every year to trick consumers into signing up for services that could prove expensive or to steal their Medicare number. Scammers can use pilfered Medicare numbers to submit

sham bills, or they can dupe beneficiaries into ordering expensive equipment that doesn't meet their needs and may not be fully covered by their plans.

Communicate these issues to your senior clients remind them to be extremely cautious about responding to mailers and advertisements they see on TV and online, and to never share Medicare numbers with anyone but their health care provider or insurance company.

New Legislation

On May 9, 2022, the Centers for Medicare & Medicaid Services (CMS) issued a final rule titled, "*Medicare Program: Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs*."

The final rule revises the Medicare Advantage (Part C) program and Medicare Prescription Drug Benefit (Part D) program regulations to implement changes related to marketing and communications, past performance, Star Ratings, network adequacy, medical loss ratio reporting, special requirements during disasters or public emergencies, and pharmacy price concessions.

Specifically, the final rule seeks to account for unscrupulous marketing behaviors by requiring third-party marketing organizations (TPMOs) to record all enrollment conversations. However, TPMOs have already had this requirement in place. What is different in this final rule is how TPMOs are being defined. The new definition of TPMO is overly broad and now includes individual agents and brokers—who will now be subject to two new requirements: Required disclaimer; and Recording Sales Calls.

Required Disclaimer

The first new rule requires a new disclaimer to be communicated to Medicare beneficiaries. The disclaimer must say,

> *"We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options."*

The disclaimer must be:

- Verbally stated during the first minute of a sales call,
- Electronically conveyed when communicating with a Medicare beneficiary through email, online chat, or any other electronic means,
- Prominently displayed on agent or broker (TPMO) websites, and
- Included in any TPMO marketing materials, such as printed materials or television advertisements.

Recording Sales Calls

The second requirement will be somewhat burdensome to many agents and brokers. It requires agents and brokers to record (and retain copies) all phone calls that are part of the "chain of enrollment." Any phone call that involves lead generation, marketing, sales, and enrollment related functions must be recorded. If the call involves any steps taken by a Medicare beneficiary from becoming aware of a Medicare plan all the way to making an enrollment decision, the call must be recorded.

Some examples of calls that will need to be recorded include:

- Calling on a lead who has requested to be contacted, 2
- Scheduling an appointment to meet with a prospective client,
- Discussing plan specific details,
- Reviewing covered drugs and in-network providers,
- Collecting or documenting scope of appointment forms, and
- Performing a telephonic enrollment. It seems that most calls will need to be recorded by agents and brokers.

The new compliance rules apply to any Medicare Advantage or Part D plan that has an effective date on or after January 1, 2023. Agents and brokers can begin discussing 2023 plans with prospective clients as early as October 1, 2022, so these new requirements are quickly approaching.

You can view the new rules at:
Federal Register :: Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

Further Reading

Kaiser Family Foundation, "*Medicare Advantage Plans*," https://www.kff.org/medicare/fact-sheet/medicare-advantage/

Kaiser Family Foundation, "2025 Medicare Advantage Plan Choices are Stable, Following Years of Steady Growth ; Published October 15, 2024 https://www.kff.org/policy-watch/2025-medicare-advantage-plan-choices-are-stable-following-years-of-steady-growth/

Medpac, Report to the Congress: Medicare and the Health Care Delivery System, July 2023; https://www.medpac.gov/wp-content/uploads/2023/03/Ch11_Mar23_MedPAC_Report_To_Congress_SEC.pdf#page=19

Better Medicare Alliance, "State of Medicare Advantage Report, May 2021 https://bettermedicarealliance.org/wp-content/uploads/2021/05/BMA-State-of-MA-Report-2021.pdf

CMS 2023 Medicare Advantage and Part D Star Ratings https://www.cms.gov/files/document/2023-medicare-star-ratings-fact-sheet.pdf

CMS, Medicare Plan Finder, https://www.medicare.gov/plan-compare/#/?lang=en

CMS, Medicare Communications and Marketing Guidelines 2022 https://www.cms.gov/files/document/medicare-communications-and-marketing-guidelines-3-16-2022.pdf

Chapter 13
Review Questions

1. Medicare Advantage (MA) is also known as:

( ) A. Medicare Part A
( ) B. Medicare Part B
( ) C. Medicare Part C
( ) D. Traditional Medicare

2. Which of the following enacted by Congress created the Medicare + Choice Program?

( ) A. The Balanced Budget Act of 1997
( ) B. Social Security Act of 1965
( ) C. Deficit Reduction Act of 2005
( ) D. Omnibus Reconciliation Act of 1987

3. Which type of Medicare Advantage Plan typically charges a set monthly premium and nominal copayments for services instead of Medicare's coinsurance and deductibles?

( ) A. PPO plans
( ) B. HMO plans
( ) C. Medical Savings Accounts (MSA)
( ) D. Special Needs Plan (SNP)

4. Which type of Medicare Advantage plan is like Health Savings Accounts?

( ) A. Preferred Provider Organization (PPO)
( ) B. Special Needs Plan (SNP)
( ) C. Health Maintenance Organization (HMO)
( ) D. Medicare MSA Plans

5. The MA Fall Open (Annual) Enrollment Period occurs every year between which of the following dates?

( ) A. October 15–December 7
( ) B. January 1–July 31
( ) C. September 1–December 31
( ) D. July 1–September 7

CHAPTER 14

MEDICARE PART D

Overview

This chapter provides an in-depth examination of Medicare Part D**,** the federal program that offers prescription drug coverage to Medicare beneficiaries. As a critical component of comprehensive healthcare planning for older Americans, Part D presents unique coverage structures, cost-sharing responsibilities, and enrollment considerations that financial and insurance professionals must understand when advising clients.

The chapter begins by reviewing the legislative history and development of Medicare Part D**,** tracing its establishment under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. It then explores the administration and funding of the program, including the role of the Centers for Medicare & Medicaid Services (CMS) and private insurers in offering Part D plans.

Participants will gain a clear understanding of eligibility requirements**,** enrollment periods, and the differences between stand-alone Prescription Drug Plans (PDPs) and integrated Medicare Advantage Prescription Drug Plans (MA-PDs)**.** The chapter also outlines the structure of various plan types, comparing coverage tiers, premiums, deductibles, and co-payments across available options.

A detailed explanation of the Part D benefit design parameters—including the standard benefit structure, initial coverage limit, coverage gap ("donut hole"), and catastrophic coverage—is provided to help professionals explain plan mechanics and cost exposure to clients. Learners will also be able to identify which prescription drugs are and are not covered under Part D formularies and how exceptions, step therapy, and prior authorization processes function.

Finally, the chapter equips financial and insurance professionals with the knowledge to guide clients through annual enrollment decisions**,** including when a beneficiary can join, switch, or disenroll from a Part D plan, and how those decisions impact overall healthcare and financial planning.

By mastering the intricacies of Medicare Part D, professionals will be better positioned to help clients make informed choices, avoid coverage gaps, and optimize their out-of-pocket prescription drug costs.

Learning Objectives

Upon completion of this chapter, you will be able to:

- Describe the history of Medicare Part D.
- Explain the administration and funding of Medicare Part D.
- Determine eligibility for Medicare Part D.
- Outline the differences between Medicare Part D stand-alone plans (PDPs) and Medicare Advantage-PD (MA-PDs) plans:
- Identify the various types of prescription drug plans offered.
- Identify the costs and benefits of the various prescription drug plans.
- Explain the Part D Benefit Design Parameters.
- Distinguish which drugs are and are not covered under Part D; and
- Manage when a beneficiary may join, switch, or exchange their Part D plan.

History of Part D

When Medicare Parts A and B were first enacted in 1965, it did not provide prescription drug coverage, and prescription drugs accounted for a small portion of health care costs.

With those costs increasing dramatically and with retiree drug costs now averaging 50 percent to 60 percent of employers' health benefit expenditures, it had become increasingly clear that the original law's lack of prescription drug benefits was a significant missing component.

In 2002, a Congressional conference committee report made the following comments about the goal of providing prescription drugs to seniors as follows:

> *"The typical senior now takes more than 20 prescriptions a year to improve their health or manage their diseases. While seniors are taking more drugs than any other demographic group, they are often paying the highest prices because about 25% of seniors have no prescription drug coverage. Similarly, low-income beneficiaries must often make unacceptable choices between life-saving medicines and other essentials. The addition of a prescription drug benefit to Medicare, while providing seniors additional choices in how they receive their health services, is a critical modernization of the program."*

This report led to the narrow passing in Congress of the "*Medicare Prescription Drug Improvement and Modernization Act of 2003"* (the "MMA"), which on December 8, 2003, President George W. Bush signed into law. This law established a voluntary drug benefit for Medicare beneficiaries and created the new Medicare Part D program. In short, the Medicare Modernization Act (MMA) and the Medicare Prescription Drug Improvement feature give Medicare beneficiaries, seniors, and disabled citizens eligible for Medicare access to drug coverage that began January 1, 2006.

A press release from the White House announcing the Medicare Part D legislation stated the following:

> *"With the Medicare Act of 2003, our government is finally bringing prescription drug coverage to the seniors of America. With this law, we're giving older Americans better choices and more control over their health care, so they can receive the modern medical care they deserve...Our nation has the best health care system in the world. And we want our seniors to share in the benefits of that system. Our nation has made a promise, a solemn promise to America's seniors. We have pledged to help our citizens find affordable medical care in the later years of life. Lyndon Johnson established that commitment by signing the Medicare Act of 1965. And today, by reforming and modernizing this vital program, we are honoring the commitments of Medicare to all our seniors."*
>
> President George W. Bush, White House Press Release, 12/08/2003

All 66 million enrollees in Medicare, including those ages 65 and older and those under age 65 with permanent disabilities, have access to the Medicare drug benefit program through private plans approved by the federal government.

Part D Administration

The Centers for Medicare and Medicaid Services (CMS) is responsible for administering the Medicare Part D Prescription Drug Program. However, private insurance carriers implement the various Medicare Part D plans across the country under the direction of CMS.

Part D SMI Trust Fund

The total assets of the account amounted to approximately $15.7 billion at the end of 2023. During calendar year 2024, total Part D expenditure was approximately $146.2 billion. Government contributions were provided on an as-needed basis to cover the portion of expenditures that Medicare subsidies support. Total Part D receipts were $149.3 billion. As a result, total assets in the Part D account increased to $18.8 billion as of December 31, 2024.

Table 14.1 illustrates a statement of the revenue and expenditures of the Part D account of the SMI Trust Fund in the calendar year (CY) 2024 and its assets at the beginning and end of the calendar year, based on the 2025 Medicare Trustees Report.

Table 14.1
Part D Medicare Data for Calendar Year 2024

	Part D
Assets at end of 2023 (billions)	$15.7
Total Income	$149.3
Payroll taxes	-
Interest	$0.3
Taxation of benefits	-
Premiums	$19.3
General revenue	$111.6
Transfer from States	$18.0
Other	$0.1
Total expenditures	$146.2
Prescription drugs	$145.7
Administrative expenses	$0.5
Net change in assets	$3.1
Assets at end of 2022	$18.8
Enrolled (millions)	
Aged	49.0
Disabled	6.2
Total	55.2
Average benefit per enrollee	$2,638

Source: Board of Trustees, 2025. Table III. D1.
2025 Medicare Trustees Report (cms.gov)

Revenue

The major sources of revenue for the Part D account are:

- Contributions of the Federal Government authorized to be apportioned and transferred from the general fund of the Treasury.
- Premiums paid by eligible persons who voluntarily enroll; and
- Contributions from the States.

Of the total Part D revenue in 2024, total premium payments, including those paid directly to Part D plans, amounted to an estimated $18.6 billion or 12.5 percent of total revenue. Contributions received from the general fund of the Treasury amounted to $111.6 billion, which accounted for 74.7 percent of total revenue. The payments from the States were $18.0 billion, which accounted for 12.0 percent of total revenue .

Another source of Part D revenue is interest received on investments held by the Part D account. Since this account holds a low amount of assets, and only for brief periods of time, the interest on the investments of the account in calendar year 2024 was $0.3 billion. Finally, law enforcement and other settlements were negligible.

Expenditures

Part D expenditures include both the costs of prescription drug benefits provided by Part D plans to enrollees and Medicare payments to retiree drug subsidy (RDS) plans on behalf of beneficiaries who obtain their primary drug coverage through such plans. Unlike Parts A and B of Medicare, the Part D account in the SMI trust fund does not directly support all Part D expenditures. Enrollee premiums that are paid directly to Part D plans and thus do not flow through the Part D account, finance a portion of these expenditures. However, these premium amounts are included in the Part D account operations (both income and expenditures) presented in this report. Total expenditures are characterized as either benefits (representing the gross cost of enrollees' prescription drug coverage plus RDS amounts) or Federal administrative expenses.

All expenses incurred by the Department of Health and Human Services, the Social Security Administration, and the Department of the Treasury in administering Part D are charged to the account. These administrative duties include making payments to Part D plans, fraud and abuse control activities, and experiments and demonstration projects designed to improve the quality, efficiency, and economy of health care services.

In addition, Congress has authorized expenditures from the trust funds for construction, rental and lease, or purchase contracts of office buildings and related facilities for use in connection with the administration of Part D. The account expenditure includes such costs. However, the statement of Part D assets presented in this report does not carry the net worth of facilities and other fixed capital assets, because the value of fixed capital assets does not represent funds available for benefit or administrative expenditures and is not, therefore, pertinent in assessing the actuarial status of the funds.

Of the $146.2 billion in total Part D expenditures in 2024, $145.7 billion represented benefits, as defined above, and the remaining $0.5 billion reflected Federal administrative expenses. The Medicare direct premium subsidy payments and enrollee premiums implicitly cover administrative expenses incurred by Part D plans.

The total assets of the Part D account as of December 31, 2024, were higher than in 2023 primarily because of the increased advanced payments to Part D plans required in 2025 as a result of the benefit redesign under the Inflation Reduction Act of 2022.

For 2025, Medicare's actuaries estimate that Part D plans will receive direct subsidy payments averaging $1,417 per enrollee overall, $1,504 for enrollees receiving the LIS, and $445 in reinsurance payments for high-cost enrollees; employers are expected to receive, on average, $640 for retirees in employer-subsidy plans. Part D plans also receive additional risk-adjusted payments based on the health status of their enrollees, and plans' potential total losses or gains are limited by risk-sharing arrangements with the federal government ("risk corridors").

As of 2025, Medicare's reinsurance payments to plans for total spending incurred by Part D enrollees above the catastrophic coverage threshold will subsidize 20% of brand-name drug spending and 40% of generic drug spending, down from 80% in previous years, due

to a provision in the Inflation Reduction Act. With this change in effect, Medicare's aggregate reinsurance payments to Part D plans are projected to account for 17% of total Part D spending in 2025, based on KFF analysis of data from the 2024 Medicare Trustees report. This is a substantial reduction from 2024, when reinsurance spending had grown to account for close to half of total Part D spending (46%). Moving forward, the largest portion of total Part D spending will be accounted for by direct subsidy payments to plans (54% of total spending in 2025).

Future of Part D SMI Trust Fund

Part D benefit payments have experienced an erratic growth pattern throughout the history of the program. Expenditures have been increasing substantially, reflecting not only rapid growth in enrollment but also multiple prescription drug cost and utilization trends that have varying effects on underlying costs. For example, while drug costs have been increasing more rapidly than other categories of medical spending, there has been a substantial increase in the proportion of prescriptions filled with low-cost generic drugs that has helped constrain cost growth and, at the same time, a significant increase in the cost of specialty drugs that has increased cost growth. Additionally, direct and indirect remuneration (DIR) has dramatically increased as a percentage of gross drug spending, a factor that has significantly slowed Part D spending growth.

Pent-up demand for certain classes of drugs or new drugs entering the market can also increase overall growth in drug expenditures and result in higher program costs. In 2023, actual drug expenditures were significantly higher due to the unanticipated rapid increase in the use of antidiabetic drugs. This increased use is projected to continue.

Legislation and policy changes also contribute to the volatility of the annual growth rates. For example, the coverage gap gradually closed from 2012 through 2020, increasing plan benefits and resulting in higher Part D expenditures and premiums. In addition, the policy to pay advanced reinsurance amounts to the employer/union-only group waiver plans, beginning in 2017, affects the timing of the reinsurance payments, which were previously provided exclusively through the reconciliation process.

Two recent legislation and policy changes have significantly affected Part D expenditures. First, a pharmacy price concessions policy shifts pharmacy rebates to reduce point-of-sale drug prices, effective January 1, 2024. The reduction in rebates results in increased Medicare expenditures. Second, the inflation Reduction Act of 2022 (IRA) will redesign the standard Part D benefit to provide reduced beneficiary out-of-pocket costs while increasing Federal Spending beginning in 2023, with the full effects of the benefit redesign to be implemented in 2025. More than offsetting these additional costs by the end of the short-range projection are program savings resulting from the lowering drug price growth through price negotiation and inflation rebates. The impact of negotiated prices begins in 2026 and will phase in over the next several years as the prices for more drugs are negotiated.

Accordingly, over the next 10 years, aggregate benefits are projected to increase at a rate of 6.3 percent annually, on average, while the average per capita rate of growth is projected to be 3.5 percent.

As with Part B, income and outgo would remain in balance as a result of the annual adjustment of income from premiums and general fund transfers to cover costs. The appropriation for Part D government contributions has generally been set such that amounts can be transferred to the Part D account on an as-needed basis; under this process, there is no need to maintain a contingency reserve. The Part D account reflects a policy to transfer amounts from the Treasury into the account 5 business days before the benefit payments to the plans.

The Trustees project that the Part D account of the SMI trust fund will remain in financial balance for all future years because beneficiary premiums and general fund transfers are assumed to be set at a level to meet expected costs each year.

Types of Medicare Part D Plans

A beneficiary can obtain the Part D drug benefit by enrolling in one of the following two types of private plans:

- Medicare Prescription Drug Plans (stand-alone plans). These plans (sometimes called "*PDPs*") add drug coverage to Original Medicare, and some Medicare Private Fee-for-Service (PFFS) Plans; and
- Medicare Advantage (MA) Plans. Medicare Advantage Plan (MA), like an HMO or PPO, are other Medicare health plans that offer Medicare prescription drug coverage. If the beneficiary is a member of one of these plans, they would receive all of their Part A and Part B coverage, and prescription drug coverage (Part D) through these plans. Medicare Advantage (MA) plans with prescription drug coverage are sometimes referred to as "*MA-PDs*."

In 2024, 53 million Medicare beneficiaries are enrolled in Medicare Part D plans, including employer-only group plans; of the total, 57% are enrolled in MA-PDs and 43% are enrolled in stand-alone (see Table 14.2). Another 0.8 million beneficiaries are estimated to have drug coverage through employer-sponsored retiree plans where the employer receives a subsidy from the federal government equal to 28% of drug expenses between $590 and $12,150 per retiree in 2025. Several million beneficiaries are estimated to have other sources of drug coverage, including employer plans for active workers, FEHBP, TRICARE, and Veterans Affairs (VA). Roughly 11% of people with Medicare are estimated to lack creditable drug coverage.

Recent years have seen a growing divide in the Part D plan market between stand-alone PDPs, where the number of plans has generally been trending downward over time in conjunction with a reduction in PDP enrollment, and MA-PDs, where plan availability and enrollment have grown steadily in recent years. The widespread availability of low or

zero-premium MA-PDs, while PDPs charge substantially higher premiums, could tilt enrollment even more towards Medicare Advantage plans in the future.

Table 14.2
Medicare Part D Enrollment Has Declined in Stand-Alone PDPs While Increasing Steadily in MA-PD Plans

Year	PDP (non-employer)-	MA-PD (non-employer	Employer-only group PDP	Employer-only group MA-PD
2006	15.2m	5.2m	632.3k	774k
2010	16.2m	8.3m	950.4k	1.2m
2015	19.0m	12.7m	4.6m	1.8m
2020	20.2m	18.8m	4.6m	2.4m
2021	19.5m	20.8m	4.4m	2.8m
2022	18.8m	22.8m	4.3m	3.0m
2023	18.3m	24.8m	3.9m	3.5m
2024	17.9m	26.5m	4.9m	3.8m

Source: Kaiser Family Foundation published October 9, 2024;
https://q1medicare.com/PartD-2025MedicarePartD-PlanStatistics.php?utm_source=partd&utm_medium=textlink&utm_campaign=SpecialFeatures

As of June 2024, 14.3 million Part D enrollees receive premium and cost-sharing assistance through the LIS program. As with overall Part D enrollment, more people receiving LIS are enrolled in MA-PDs than PDPs. Beneficiaries who are dual-eligible individuals, those enrolled in Medicare Savings Programs (QMBs, SLMBs, Qis), and those who receive Supplemental Security Income payments from Social Security automatically qualify for the additional assistance, and Medicare automatically enrolls them into PDPs with premiums at or below the regional average (the Low-Income Subsidy benchmark) if they do not choose a plan on their own. Other beneficiaries are subject to both an income and asset test and need to apply for the Low-Income Subsidy through either the Social Security Administration or Medicaid.

Part D Highlights For 2025

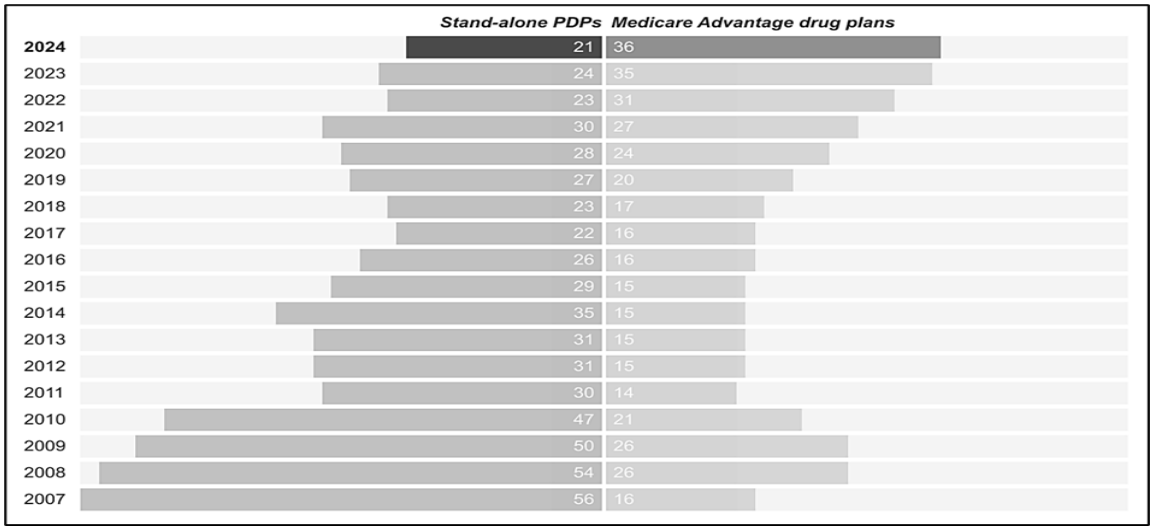
- In 2025, 524 PDPs will be offered across the 34 PDP regions nationwide (excluding the territories), a 26% decrease from 2024. Despite the overall reduction, beneficiaries in each state will have a choice of at least a dozen stand-alone plans, plus many Medicare Advantage drug plans.
- Compared to 2024, fewer plans will be available for enrollment of Part D Low-Income Subsidy (LIS) beneficiaries for no premium ("benchmark" plans) in 2025 – 115 plans, a 9% reduction compared to 2024. The number of benchmark plans will vary from 2 to 6 across states.
- Changes to the Medicare Part D benefit under the Inflation Reduction Act are taking effect in 2025, including a new $2,000 out-of-pocket cap, an increase in the share of drug costs above the cap paid for by Part D plans and drug manufacturers, and a reduction in Medicare's share of these costs.

- In 2024, 53 million of the 67 million Medicare beneficiaries are enrolled in Medicare Part D plans, including employer-only group plans; of the total, 57% are enrolled in MA-PDs and 43% are enrolled in stand-alone PDPs. As of June 2024, 3 million receive premium and cost-sharing assistance through the LIS program.
- The Congressional Budget Office (CBO) estimates that spending on Part D benefits will total $137 billion in 2025, representing 15% of net total Medicare spending. Funding for Part D comes from general revenues (75%), beneficiary premiums (15%), and state contributions (13%).
- Medicare's aggregate reinsurance payments to Part D plans are projected to account for 17% of total Part D spending in 2025, a substantial reduction from 2024. This change reflects the reduction in Medicare's liability for catastrophic drug costs from 80% in 2024 to 20% for brands and 40% for generics in 2025.

Part D Drug Plan Availability in 2025

In 2025, 524 PDPs will be offered across the 34 PDP regions nationwide (excluding the territories), a 26% decrease from 2024 and the lowest number of PDPs available since the Part D program's beginning in 2006 (Figure 14.3). While the availability of stand-alone PDPs has been trending downward over time, along with a decline in PDP enrollment, the availability of Medicare Advantage drug plans has expanded in recent years, and more people in Medicare are now getting Part D Drug coverage through Medicare Advantage plans.

Figure 14.3
The Average Medicare Beneficiary Has a Choice of Close to 60 Medicare Plans Offering Drug Coverage in 2024, Including 21 Stand-Alone Drug Plans and 36 Medicare Advantage Drug Plans



In 2025, 524 PDPs (standalone) will be offered nationwide across the 28 PDP regions (excluding the territories). That will be 16 plans per region. This represents a decrease of 185 PDPs compared to 709 plans in 2024 and certainly still a steep decline in the number of PDPs available since Part D started in 2006 with 1,875 plans (see Table 14.4).

Table 14.4
2025 National Medicare Part D Plan Statistics*

Statistic	2025	Changes 25-24	2024	Changes 24-23	2023
Total Number of Part D Drug Plans	524	-185	709	-92	801
Avg. Number of Part D Plans per Region	16	-5	21	-3	24
Number of Enhanced (EA) Plans	298	-5	443	-54	497
Average Enhanced Plans per Region	9	-4	13	-2	15
Number of Basic (BA, DS, AE) Plans	226	-40	266	-38	304
Avg Number of Basic Plans per Region	7	-1	8	-1	9
Number of $0 Deductible Plans	103	-29	132	-4	136
Avg Number of $0 Deductible Plans per Region	79	-1	8	-1	9
$0 Deductible Plans (Percentage)	15%	1%	15%	-2%	16%
Number of Plans with a Premium under $25	157	7	150	-34	184
Percentage of Plans with a Premium under $25	30%	9%	21%	-2%	23%
Lowest Cost PDP (Premium)	$0.00	$0.00	$0.00	$-1.60	$1.60
Highest Cost PDP (Premium)	$190.80	$-4.30	$195.10	$-6.00	$201.10
Average PDP Premium (Cost)	$61.98	$2.21	$59.77	$10.80	$48.97
% Change in Avg. PDP Costs	--	4%	--	22%	--
Average Weighted PDP Premium**	$39.36	$-1.87	$41.23	$1.63	$39.60
Number of LIS PDPs	115	-11	126	-65	191
Number of PDPs with Premium Decrease	210	40	170	-55	225
Number of PDPs with No Premium Change	17	17	0	0	0
Number of PDPs with Premium Increase	264	-305	569	71	498
Percentage of People with a Premium Increase	38.5%	-34.14%	73%	8.44%	64%
Weighted Average Increase for People with a Premium Increase	$20.61	$6.27	$14.34	$7.34	$7.00

Note: *Stand-alone Medicare Prescription Drug Plans (PDP)s only. Data for MA-PD plans not included. Sanctioned plans are included in this data. The data is calculated per region. For example. A plan which is available in CMS Region 6 which includes PA and WV is counted once, not twice.
**The plan premium weighted averages are calculated by multiplying the plan premium by the number of enrollees in the plan to give more "weight" to plans with more members.

. **Source: Q1 Group LLC; https://q1medicare.com/PartD-2025MedicarePartD-PlanStatistics.php?utm_source=partd&utm_medium=textlink&utm_campaign=SpecialFeatures**

Part D Beneficiary Costs

Payments for Medicare Part D prescription drug plans (PDPs) can be broken into the following three categories:

Part D Monthly Premium

Key elements related to understanding Part D premiums are the base beneficiary premium, average basic Part D premium, average supplemental Part D premium, and average total Part D premium.

- *Base Beneficiary Premium:* The national base beneficiary premium is the starting point for calculating a plan-specific basic Part D premium. This value is calculated per a statutory formula, using a percentage of bids and estimates of reinsurance costs submitted by certain Part D plans for the statutory minimum level of coverage Part D plans are required to provide (known as the "basic" benefit). Beginning in 2024, the annual increase in the base beneficiary premium is capped by the prescription drug law's premium stabilization provision, not to exceed 6% per year. So, for 2025, the base beneficiary premium will increase to $36.78, an increase of 6% from $34.70 in 2024.
- *Average Basic Part D Premium:* The base beneficiary premium is used to calculate a plan-specific monthly premium for the basic benefit offered by each Part D plan, called the basic Part D premium. Specifically, the plan-specific basic Part D premium is calculated as the sum of the base beneficiary premium and the difference between the plan's monthly bid and the national average monthly bid amount. Thus, the plan-specific basic premium can be higher or lower than the base beneficiary premium, depending on if the plan's bid is higher or lower than the national average monthly bid amount. These plan-specific basic premiums across all plans that submit bids are then averaged together to calculate the average basic Part D premium. Part D enrollees pay the basic premium themselves unless they are eligible for a premium subsidy through the Low-Income Subsidy (LIS) Program or enrolled in a MA plan with Part D (MA-PD plan) that applies MA rebates toward lowering the beneficiary's Part D premium obligation.
- *Average Total Part D Monthly Premium:* As discussed above, the average total Part D premium is the sum of the average basic premium and the average supplemental premium for plans with enhanced coverage and is the most accurate projection of what people with Part D are likely to pay on average in premiums, before subsidies and the application of MA rebates are considered.
    - CMS projects the average total Part D premium to decrease by $7.45 in 2025, from $53.95 in 2024 to $46.50 in 2025.

Yearly Deductible

This is the amount the Medicare beneficiary pays for their prescriptions before the plan begins to pay. Some Medicare Part D plans have an initial deductible ($590 in 2025). Some PDPs have no initial deductible or a $0 deductible, providing coverage when the

beneficiary purchases their first prescriptions. In 2025, there will be only 79 plans with a $0 deductible (a decrease of 24% from 103 plans in 2024), with an average of 2 per region. Note: A beneficiary may pay a higher monthly premium for PPDs with no deductible. Finally, when the beneficiary uses their Medicare Part D PDP, their actual prescription costs will vary depending on the drug plan they choose.

Copayment or Coinsurance

The Medicare beneficiary pays these amounts for their prescriptions after they pay the deductible. Medicare beneficiary pays their share, and the plan pays its share for covered drugs.

Part D IRMAA Premiums

Since 2011, as required by Section 1860D-13(a)(7) of the Social Security Act, if a beneficiary's "modified adjusted gross income" (MAGI) is greater than the specified amounts ($106,000 in 2025 for a beneficiary filing an individual income tax return or married and filing a separate return, and $212,000 for a beneficiary filing a joint tax return), then the beneficiary is responsible for a larger portion of the total cost of Part D benefit coverage. In addition to the normal Part D premium ($36.78) paid to a plan (as discussed above), such beneficiaries must pay an income-related monthly adjustment amount (IRMAA). Unlike the normal Part D premium, beneficiaries will not pay the Part D IRMAA to Part D plans. Instead, the Part D IRMAA premium will be collected by the federal government.

Like the Part B IRMAA brackets, the Part D income tax brackets used to determine the Part D premium will also increase beginning January 1, 2020, for the first time in a decade, the income brackets used to determine the Part D premium surcharges for high-income retirees will be indexed to inflation, except for the top-level income thresholds of $500,000 for individuals and $750,000 married couples filing jointly that were added in 2019. Those top tiers will be indexed to inflation starting in 2028.

Table 14.5 illustrates the 2025 Part D IRMAA to be paid by beneficiaries who file individual tax returns (including those who are single, head of households, qualifying widows or widowers with dependent children, or married individuals filing separately who lived apart from their spouses for the entire taxable year), or who file a joint return.

Table 14.5
Part D IRMAA for Single/Head of Household/Qualifying Widow(ers) with Dependent Children/, or Married filing Jointly Taxpayers in 2025

Beneficiaries who file individual tax returns with 2023 income:	Beneficiaries who file joint tax returns with 2023 income:	Applicable %	Part D IRMAA
Up to $106,000	Up to $212,000	N/A	$0.00
> $106,001–$133,000	> $212,000–$266,000	35%	$13.70 + plan premium
> $133,000–$167,000	> $266,000–$334,000	50%	$35.30+ plan premium
> $167,000–$200,000	> $334,000–$400,000	65%	$57.00 + plan premium
> $200,000–$500,000	> $400,000–$750,000	80%	$78.60 + plan premium
Greater than $500,000	Greater than $750,000	85%	$85.80 + plan premium

Source: 2025 Medicare Parts A & B Premiums and Deductibles | CMS
**Plus, any late enrollment or re-enrollment fees for prescription drug coverage

Table 14.6 illustrates the monthly premium rates to be paid by married beneficiaries but file separate returns from their spouses and live with their spouses at any time during the taxable year.

Table 14.6
Part D IRMMA Premiums MFS 2025

Beneficiaries who are MFS, with 2023 income of:	Part D IRMAA
Up to $106,000	$0.00
>$106,000–$394,000	$78.60
Greater than $394,000	$85.80

Source: 2025 Medicare Parts A & B Premiums and Deductibles | CMS
**Plus any late enrollment or re-enrollment fees for prescription drug coverage

According to CMS, an estimated 30% of Part D enrollees will pay IRMAA Part D premiums in 2025. Like Part B, Part D enrollees can also request an IRMAA adjustment due to a life changing event (LCE).

2025 Defined Standard (Prescription Drug Plan Parameters

Each year, the Centers for Medicare and Medicaid Services (CMS) releases the Medicare Part D drug plan benefit parameters for the "Defined Standard Benefit" plan and the Low-Income Subsidy (LIS) benefits. Medicare Part D plan providers then can use these standardized benefit parameters to determine drug plan coverage for the next plan year.

The CMS "Part D Benefit Parameters for Defined Standard Benefit" outline the minimum allowable Medicare Part D plan coverage. However, CMS allows Medicare Part D plans to offer a variation on the defined standard benefits (for example, a Medicare Part D plan can offer a $0 Initial Deductible instead of the standard deductible).

Accordingly, although an actual Part D drug plan's coverage can vary from the CMS standardized benefits, you can use these parameters as a preview of how Medicare Part D plan coverage may change.

Here are a few highlights of the defined standard Medicare Part D plan changes from 2024 to 2025.

Initial Deductible

If the Medicare Part D plan has an Initial Deductible, the beneficiary will usually pay 100% for their medications, and the amount they pay will count towards the Donut Hole. However, some Medicare Part D prescription drug plans with an Initial Deductible cover some lower-cost medications in the Initial Deductible. So, whether the beneficiary or the plan pays for their medications in the Initial Deductible, the retail value of their medications counts towards their Initial Coverage Limit (see next phase) and determines when the beneficiary enters the Donut Hole or Coverage Gap. The standard Initial Deductible can change each year. In 2025, the Initial Deductible will increase from $545 in 2024 to $590 in 2025 (up from $505 in 2023).

The average Part D drug deductibles have steadily climbed since 2014, and now with a maximum of $590 in 2024 (see Table 14.7).

Table 14.7
Part D Deductibles 2015–2025

Year	Deductible	Year	Deductible
2015	$320	2021	$445
2016	$360	2022	$480
2017	$400	2023	$505
2018	$405	2024	$545
2019	$415	2025	$590
2020	$435		

Source: https://q1medicare.com/PartD-The-MedicarePartDOutlookAllYears.php

Initial Coverage Phase

The Initial Coverage Phase will cease to exist in 2025 and the initial coverage phase will instead be replaced by the annual out-of-pocket spending threshold (TrOOP or RxMOOP). Accordingly, the 2024 initial coverage phase (retail cost of formulary drug purchases before entering the Coverage Gap) of $5,030 will be replaced with the 2025 annual out-of-pocket spending limit (TrOOP pr RxMOOP) of 2,000 – equating to ta total retail formulary drug cost of around $6,380 (excluding covered insulin and vaccine costs).care beneficiary's retail drug costs exceed $5,030 (was $4,660 in 2023).

Coverage Gap (Donut Hole)

In 2025 the Donut Hole (coverage Gap) will no longer exist and will be replaced with a $2,000 out-of-pocket (OOP) spending limit. When a person reaches the $2,000 maximum cap or Part D maximum out-of-pocket spending limit (RxMOOP), they will not pay any additional costs for formulary drugs for the remainder of the year. In 2025, the $2,000 RxMOOP should be reached when a person purchases Medicare Part D formulary drugs with a retail value of about $6,23. (The $2,000 RxMOOP can change each year like other Medicare Part D parameters.

This means that all Medicare beneficiaries will not pay any additional costs for formulary drugs once they reach the 2025 out-of-pocket spending limit (RxMOOP of $2,000.

Total Annual Out-of-Pocket Spending Threshold

The annual out-of-pocket spending limit will decrease from $8,000 in 2024 to $2,000 in 2025. The TrOOP threshold now represents the maximum out of pocket spending limit for formulary drugs (RxMOOP).

Catastrophic Coverage phase

The Catastrophic Coverage phase will remain the third phase of Medicare Part D coverage, however, since January 1st, 2024, Medicare beneficiaries will no longer pay any cost for formulary drugs purchased in the Catastrophic Coverage stage (after exceeding the annual TrOOP threshold or RxMOOP).

Table 14.8 illustrates the changes of the Part D Standard Benefit Parameters from 2024 to 2025.

Table 14.8
Medicare Part D Standard Benefit Parameters, 2024 vs. 2025

	2024	2025
Deductible	**Cost Sharing: 100%**	**Cost Sharing: 100%**
	Deductible: $545	Deductible: $590
Initial Coverage Phase	Cost sharing: 25% Plan Pays: 75%	**Applicable Drugs** Cost sharing : 25% Plan Pays: 65% Manufacturer Discount: 10% **Non-Applicable Drugs** Cost sharing : 25% Plan Pays: 75%
	Initial Coverage Limit: $5,030	Initial Coverage Limit: Not Applicable
Coverage Gap	**Applicable Drugs** Cost sharing : 25% Plan Pays: 5% Manufacturer Discount: 70% **Non-Applicable Drugs** Cost sharing : 25% Plan Pays: 75%	N/A
	Out-of-Pocket Threshold: $8,000	**Out-of-pocket Threshold: $2,000**
Catastrophic Phase	Plan Pays: 20 Reinsurance: 80%	Applicable Drugs Plan Pays: 65% Manufacturer Discount: 10% Reinsurance: 20% **Non-Applicable Drugs** Plan Pays: 60% Reinsurance: 40%

Extra Help (Low-Income Subsidy) Program

The federal government provides an extensive program for people needing financial assistance with the Medicare Part D program, called Extra Help (also known as Low Income Subsidy-LIS). Depending on the beneficiary's income and available financial resources, Medicare will provide "*Extra Help*" that may cover 85% to 100% of prescription costs and pay a part or all of the beneficiary's Medicare Part D premiums.

Background

Individuals eligible for Extra Help receive a full or partial subsidy up to the benchmark premium for a base plan. To get Extra Help, Medicare beneficiaries must enroll in a Medicare-approved Prescription Drug Plan. The beneficiary also will be covered during the coverage gap and will not have to pay a late enrollment penalty. Some Medicare beneficiaries are automatically eligible for Extra Help and do not need to apply. These beneficiaries are "deemed eligible" if they:

- Are entitled to Medicare Part A, Medicare Part B, or both.

- Receive Supplemental Security Income (SSI), including 1619 (b);
- Receive full Medicaid; or
- Are Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), or Qualifying Individuals (QI).

Medicare beneficiaries who do not meet the deemed eligible criteria still may be eligible for the subsidy (also known as Extra Help) based on their resources, income, and household size. These beneficiaries must file an application for Extra Help to see if they qualify.

Eligibility Criteria

Individuals must meet the following criteria to receive a full or partial subsidy. They must:

- Be entitled or enrolled in Medicare Part A or Medicare Part B.
- Reside in one of the 50 states or the District of Columbia.
- Have an annual income (including the income of their spouse if married and living together) of less than 150% of the Federal Poverty Level (FPL) for 2025 based on household size; For an individual is $22,590. For a married couple who is living together, the limit is $30,660 (additional add $8,070); and
- File a low-income subsidy (Extra Help) application or be deemed eligible.

Medicare beneficiaries do not need to be enrolled in a Prescription Drug Plan (PDP) or Medicare Advantage Plan with Drug Coverage (MA-PD) to file for Extra Help; they can file for Extra Help first. However, Extra Help assistance does not start until the beneficiary is enrolled in a plan. The Centers for Medicare & Medicaid Services (CMS) automatically enroll beneficiaries approved for Extra Help and have not selected a plan. If the beneficiary does not like the plan selected, they can select another plan or refuse enrollment.

Note: All beneficiaries are permitted $1,500 per person burial exclusion from their resources. This exclusion can be considered by either reducing the beneficiary's resources by $1,500 per person or increasing the resource limit by $1,500 per person.

Social Security counts the individual's resources, including those of a spouse living together, based on what they have at the start of the month. It is important to remember that the subsidy coverage varies depending on the Medicare beneficiary's resources and income. Resource limits can change each year. These changes can be found at www.socialsecurity.gov/extrahelp.

Resources include the value of the thing's beneficiaries own. Some examples are:

- Real estate (other than the beneficiary's primary residence);
- Bank accounts, including checking, savings, and certificates of deposit.
- Stocks.

- Bonds, including U.S. Savings Bonds.
- Mutual funds.
- Individual Retirement Accounts (IRAs); or
- Cash at home or anywhere else.

If the applicant for Extra Help has a joint account, it will be presumed that all the funds in the account belong to the applicant unless the other account holder is also applying for Extra Help.

The following are not counted:

- The primary residence.
- Personal possessions.
- Vehicle(s).
- Things that could not easily be converted to cash, such as jewelry or home furnishings.
- Property needed for self-support, such as rental property or land used to grow produce for home consumption.
- Non-business property essential to self-support.
- Life insurance policies.
- Burial plots or spaces.
- Interest earned on money set aside for burial expenses.
- Certain distributions received by an Alaska Native from an Alaska Native Regional and Village Corporation.
- Land held in trust by the United States for an individual Indian or Tribe; and
- Funds held in trust by the Secretary of the Interior for an Indian Tribe and distributed per capita to members of the tribe.

Also, certain other funds Medicare beneficiaries may have been not counted for nine months, such as:

- Retroactive Social Security or Supplemental Security Income (SSI) payments.
- Housing assistance.
- Tax advances and refunds related to earned income tax credits and child tax credits.
- Compensation received for being a victim of a crime; and
- Relocation assistance from a state or local government.

Household Size

Household size includes beneficiaries, their spouses (if they live together), and any relatives who live with them and depend on them for at least one-half of their financial support. For the Extra Help application, a relative is anyone related to the beneficiary by blood, marriage, or adoption. The size of a beneficiary's household affects the income amount CMS uses to determine eligibility for Extra Help with drug plan costs. CMS will use the Federal Poverty Level (FLPs) guidelines to make this determination.

Table 14.9 illustrates the LIS qualifications below using the 2025 Federal Poverty Level (FPL) guidelines.

Table 14.9
Full Low Income Subsidy Income Replacements (150% of FPL)
Using the 2024/2025 Federal Poverty Levels (FPL)

Persons in Family	48 Contiguous States & D.C	Alaska	Hawaii
1	$22,590	$28,215	$25,965
2	$30,660	$38,310	$35,250
3	$38,730	$48,405	$44,535
4	$46,800	$58,500	$53,820
5	$54,870	$68,595	$63,105
6	$62,940	$78,690	$72,390
7	$71,010	$88,785	$81,675
8	$79,080	$98,880	$90,960
For each additional Person, add	$8,070	$10,095	$9,285

Source: Federal Register released January 19, 2024; The 2024 poverty guidelines; https://aspe.hhs.gov/poverty-guidelines.

2025 LIS Subsidy Benchmark Premium Amounts

CMS released the 2025 low-income premium subsidy amounts (or Benchmark) for Medicare Part D plans on July 29, 2024, and in 2025, seventeen (17) regions will lower their Medicare Part D LIS benchmark premium, and seventeen (17) regions will increase their benchmark premium values, and thirty-two (32) regions will increase their benchmark premium.

The benchmark is the maximum monthly Medicare Part D premium that CMS will pay for persons qualifying for the low-income subsidy (LIS) or the Medicare Part D Extra Help program. If a person receiving the low-income subsidy (LIS) enrolls in a Medicare Part D plan that has a premium higher than the subsidy amount listed in their state, the beneficiary is responsible for paying the difference in premium.

> ***For Example***, if a beneficiary qualifies for full Extra Help benefits and lives in a state with a benchmark premium of $30, the Medicare Part D Extra Help program will pay for the premium of a "Basic" Medicare Part D plan up to this premium level (or slightly above) and they will have a $0 monthly premium for their drug coverage. If the beneficiary qualifies for partial Extra Help, their monthly premium will not be $0, but their premium will be reduced.

The number of stand-alone Medicare Part D plans qualifying for the $0 LIS premium changes each year, with the number of unique Part D drug plans leveling out over the

past years—and then decreasing again to a new-lows in 2023 and 2024 to nine (9) plans, but in 2025 will increase slightly to ten (10) plans compared to a high of 47 in 2008.

Part D Drug Formularies and Tiers

Drug Tiers are an attempt to "logically" group drugs (such as generics, preferred-generics, brand drugs, and specialty drugs) within a list (drug formulary) and each tier is associated with a set copay amount. Most formularies have between 3 and 5 tiers. Each tier costs a different amount. Each plan can divide its tiers in different ways. Below is an example of how a plan might divide its tiers. A drug in a lower tier will cost your client less than a drug in a higher tier. For example:

- Tier 1 – Preferred generic drugs - $0 co-pay.
- Tier 2 – Generic drugs - $10 co-pay.
- Tier 3 – Preferred brand-name drugs - $47 co-pay.
- Tier 4 – Non-preferred drugs - 35% of retail cost-sharing.
- Tier 5 – Specialty Tier - 25% of retail cost-sharing.

The plan's tiered co-pay amounts for each drug only apply during the initial period before the coverage gap. Once a Medicare beneficiary is in the coverage gap (AKA, the Donut hole), they must pay 100% of the prescription costs, based on prices established by the plan.

The primary differences between the formularies of different Part D plans relate to the coverage of brand-name drugs. The plan's drug list might not include a drug your client may take. However, in most cases, a similar drug that is safe and effective will be available.

The plan's drug list may change during the year because drug therapies change, new drugs are released, and new medical information becomes available. If there is a change that affects a drug a beneficiary takes, they must be notified by the plan with at least *60 days* in advance notice. He/she may have to change the drug they are using or pay more for it. In some cases, they can continue taking the drug until the end of the year.

Note: A plan isn't required to tell the beneficiary in advance if it removes a drug from its drug list because the FDA takes the drug off the market for safety reasons, but it will let them know afterward.

Part D plans are not required to pay for all covered Part D drugs. They establish their own formularies, or list of covered drugs for which they will make payment, if CMS does not find the formulary and benefits structure to discourage enrollment by certain Medicare beneficiaries. Part D plans that follow the formulary classes and categories established by the United States Pharmacopoeia will pass the first discrimination test. Plans can change the drugs on their formulary during the year with a 60-day notice to affected parties.

All Medicare prescription drug plans must provide at least a standard level of coverage set by Medicare. However, plans offer different combinations of coverage and cost-sharing. The drug lists for each plan must include a range of drugs in each prescribed category. This makes sure that people with different medical conditions can get the treatment they need. According to CMS guidelines, plan formularies must include drug classes covering all disease states and a minimum of two chemically distinct drugs in each class. Plans are required to cover all drugs in six so-called "protected" classes:

- Immunosuppressants.
- Antidepressants.
- Antipsychotics.
- Anticonvulsants.
- Antiretrovirals; and
- Antineoplastics.

All Medicare drug plans have negotiated to get lower prices for the drugs they include on their lists. This means using drugs on the plan's list will generally save your client money. Using generics instead of brand-name drugs also can save them money. Because of all these choices and rules, it is probably best for Medicare beneficiaries to seek expert help in assisting them in making the proper choice. The beneficiary should seek out financial professionals knowledgeable in this area to make sure that they choose the proper plan and at the right cost.

The scope of formulary coverage continues to vary widely across PDPs in 2025. Some plans list all drugs from the CMS drug reference file on their formularies, while other PDPs list as few as 66 percent of these drugs. However, even the most limited formularies exceed the formulary requirements established under law and CMS program guidance. The seven largest PDPs range in formulary coverage from 74 percent to 89 percent of drugs in the reference file. The average MA-PD plan enrollee is in a plan with slightly more drugs on formulary (87 percent) than PDPs. Beneficiaries retain the option of requesting an exception to have the plan cover an off-formulary drug, or they can obtain the drug by paying the full purchase price out of pocket.

Part D Excluded Drugs

While CMS does not have an established formulary, Part D drug coverage excludes drugs not approved by the Food and Drug Administration (FDA); those prescribed for off-label http://en.wikipedia.org/wiki/Off-label use; drugs not available by prescription for purchase in the United States; and drugs for which payments would be available under Parts A or B of Medicare. Part D coverage excludes drugs or classes of drugs, which may be excluded from Medicaid coverage. These may include:

- Drugs used for anorexia, weight loss, or weight gain;
- Drugs used to promote fertility and for erectile dysfunction.
- Drugs used for cosmetic purposes (hair growth, etc.).
- Drugs used for the symptomatic relief of cough and colds.

- Barbiturates and Benzodiazepines.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations; and
- Drugs where the manufacturer requires as a condition of sale any associated tests or monitoring services to be purchased exclusively from that manufacturer or its designee.

While these drugs are excluded from basic Part D coverage, drug plans can include them as a supplemental benefit, provided they otherwise meet the definition of a Part D drug. However, plans that cover excluded drugs are not allowed to pass on those costs to Medicare, and plans are required to repay CMS if they are found to have billed Medicare in these cases.

Part D Drug Pharmacies

Prescription drug plans must contract with pharmacies in the beneficiary's area, but not all pharmacies contract with all plans. Make sure the pharmacies in the plan they chose are convenient for them to access. They can check a plan's pharmacy network on the Medicare Prescription Drug Plan Finder at: www.medicare.gov or call its customer service department. Many plans also allow them to receive prescriptions through the mail, often at a lower cost.

In 2025, 100 percent of all PDPs–will use tiered pharmacy networks. By contrast, only 7 percent of PDPs (6 percent of enrollees) had a tiered pharmacy network in 2011. Enrollees in these plans pay lower cost-sharing for their prescriptions if they use pharmacies that offer preferred cost-sharing. The idea behind these arrangements is that Part D plans can negotiate discounted prices at certain pharmacies in exchange for a higher volume of sales. The lower cost-sharing creates an incentive for enrollees to use the designated pharmacies. CMS guidelines allow plans to assume preferred cost-sharing in calculating whether cost sharing is actuarially equivalent to the defined standard benefit.

Medicare Plan Finder

Medicare has made an interactive online tool called the Medicare Plan Finder (www.medicare.gov/find-a-plan) that compares coverage and costs for all plans in a geographic area. The tool allows the beneficiary to enter a list of medications along with pharmacy preferences. It can show them their total annual costs for each plan, along with a detailed breakdown of the plans' monthly premiums, deductibles, and prices for each drug during each phase of the benefit design. Plans are required to update this site with current prices and formulary information every other week throughout the year.

Part D Star Ratings

The Center for Medicare & Medicaid Services (CMS) publishes the Medicare Part D Star Ratings each year to measure the quality of drug services received by consumers enrolled in MA-PDs and Prescription Drug Plans (PDPs). The Star Rating system helps Medicare consumers compare the quality of Medicare drug plans being offered. As part of this effort, patients are empowered to make health care decisions best for them. An important component of this effort is to provide Medicare consumers and their caregivers with meaningful information about quality alongside information about benefits and costs to assist them in being informed and active health care consumers.

Medicare Advantage with prescription drug coverage (MA-PD) contracts are rated on up to 38 unique quality and performance measures, and stand-alone PDP contracts are rated on up to 12 measures. Each year, CMS conducts a comprehensive review of the measures that make up the Star Ratings by assessing the reliability of the data, clinical recommendations, and feedback received by stakeholders.

Medicare assigns a star rating from 1 to 5, with 5 being the best, for Medicare Part D (prescription drug coverage) plans. Medicare considers five categories when assigning a star rating to a Medicare Advantage plan:

- How the plan emphasizes staying healthy, including benefits like screenings, tests, and vaccines.
- How the plan manages chronic conditions.
- How responsive the plan is, as well as the quality-of-care people with the plan receive.
- Member complaint reports, which include problems in getting services, decision appeals, and how many members leave the plan each year; and
- Plan operations, like how the plan prices their drug formularies, how they make decisions about appeals, and the results from audits about the plan's quality.

Key Findings in the 2025 Star Ratings

The new 2025 Star ratings are now out for Medicare Advantage-Part D (MA-PD) health plans, and only seven plans received a five-Star rating, down from 38 in 2024. About 40 percent of plans received four Stars or higher, and about 62 percent of MA members are enrolled in these plans. The average Star rating for 2025 is 3.92, demonstrating an increasing challenge to plans to maintain or increase ratings against an evolving set of criteria, which will require the development of new strategies by health plans.

Table 14.10 details trends in the average overall Star Ratings weighted by enrollment for MA-PD contracts offering prescription drug coverage (MA-PDs) from 2024 to 2025. For the past two years, the average star ratings for Medicare Advantage and Medicare Part D prescription drug plans fell to 4.04 and 3.11 stars, respectively.

The last row in Table 14.10 shows the trend in the average overall Star Ratings weighted by enrollment for MA-PDs from 2024 to 2025, after any adjustments for extreme and uncontrollable circumstances.

Table 14.10
2024–2025 Overall Star Rating Distribution for MA-PD Contracts

Overall Rating	2024			2025		
	# of Contracts	%	Weighted by Enrollment	# of Contracts	%	Weighted by Enrollment
5 stars	38	6.97	7.64	7	1.34%	1.79%
4.5 stars	81	14.86	31.76	86	16.51	28.87
4 stars	123	22.57	36.94	116	22.26	31.47
3.5 stars	141	25.87	15.89	165	31.67	27.71
3 stars	126	23.12	6.77	123	23.61	9.16
2.5 stars	32	5.87	0.96	23	4.41	1.00
2 stars	4	0.73	0.03	1	0.19	0.01
Total Related Contracts	545	100		521	100	
Avg. star ratings	**4.04**			**3.92**		

*The average Star Rating is weighted by enrollment Source:
Factsheet: 2025 Medicare Advantage and Part D Rate Star Ratings October 10, 2024

The last row in Table 14.11 shows the average Part D ratings weighted by enrollment for stand-alone PDPs from 2022 to 2025 after any adjustments for extreme and uncontrollable circumstances. The average Star rating for 2025 is 3.06.

- Approximately 27% of PDPs (11 contracts) that will be active in 2025 received four or more stars for their 2025 Part D Rating.
- Weighted by enrollment, about 5% of PDP enrollees are currently in contracts that will have four or more stars in 2025.

Generally, higher overall Star Ratings are associated with contracts that have more experience in the MA program. MA-PDs with 10 or more years in the program are more likely to have four or more stars compared to contracts with fewer than five years in the program. For PDPs, there are very few PDPs with fewer than 10 years of experience in the program, so the relationship is not as clear. There is only one PDP with fewer than five years of experience and it received two stars. There are only three PDPs that have at least five years but fewer than 10 years of experience, and two of the three received four or more stars.

Table 14.11
2024-2025 Part D Rating Distribution for PDPs

Overall Rating	2024			2025		
	# Of Contracts	%	Weighted by Enrollment	# Of Contracts	%	Weighted by Enrollment
5 stars	2	4.17	0.04	2	4.88	0.04
4.5 stars	4	8.33	0.60	6	14.63	0.94
4 stars	12	25.00	22.82	3	7.32	3.60
3.5 stars	10	20.83	24.45	10	24.39	47.44
3 stars	14	29.17	49.56	11	26.83	10.21
2.5 stars	2	4.178	0.04	7	17.07	29.03
2 stars	4	8.33	2.48	2	4.88	8.75
1.5	0	0.00	0.00	0	0.00	0.00
Total Related Contracts	48	100		41	100	
Avg. star ratings	**3.34**			**3.06**		

*The average Star Rating is weighted by enrollment Source:
Factsheet: 2025 Medicare Advantage and Part D Rate Star Ratings October 10, 2024

Part D Enrollment

There are specific times when an enrollee can sign up for Medicare prescription drug coverage (Part D) or amend the coverage they already have:

- When an enrollee first becomes eligible for Medicare or when they turn 65, during their *Initial Enrollment Period* (see Table 14.12).
- During certain *Open Enrollment Periods* that happen every year (see Table 14.13); and
- Under certain circumstances that qualify the enrollee for a *Special Enrollment Period* (SEP). (See Table 14.14).

Table 14.12
Part D Initial Enrollment Period

If this describes your client	They can	At this time
Newly eligible for Medicare because they turned 65.	Sign up for a Medicare Prescription Drug Plan.	During the 7-month period that starts 3 months before the month they turn 65, includes the month they turn 65, and ends 3 months after the month they turn 65.
Newly eligible for Medicare because they're disabled (under 65). Note: This doesn't apply if they have ESRD.	Sign up for a Medicare Prescription Drug Plan.	During the 7-month period that starts 3 months before their 25th month of disability and ends 3 months after their 25th month of disability.

Already eligible for Medicare because of a disability and turning 65.	Sign up for a Medicare Prescription Drug Plan. Switch from the current Medicare Prescription Drug Plan to another plan. Drop a Medicare Prescription Drug Plan completely.	During the 7-month period that starts 3 months before the month they turn 65, includes the month they turn 65, and ends 3 months after the month they turn 65.
They DON'T HAVE Medicare Part A coverage, and they enroll in Medicare Part B during the Part B General Enrollment Period (January 1–March 31).	They can sign up for a Medicare Prescription Drug Plan.	Between April 1–June 30. Coverage will start July 1.

Table 14.13
Part D Open Enrollment Periods

Enrollment Period	What the Enrollee Can Do
October 15–December 7 Medicare Open Enrollment Period (Changes will take effect on January 1.)	Join a Medicare Prescription Drug Plan. Switch from one Medicare Prescription Drug Plan to another Medicare Prescription Drug Plan. Drop the Medicare prescription drug coverage completely.
MA Open Enrollment Period January 1–March 31	If the enrollee switches from a Medicare Advantage plan to Original Medicare, they will have until March 31 to also join a Part D Prescription Drug Plan to add drug coverage. The prescription drug coverage will begin the first day of the month after the plan gets the enrollment form.

Table 14.14
Part D Special Enrollment Periods

Changes where enrollee lives		
If this describes your client…	**They can…**	**At this time…**
Moved to a new address that isn't in the plan's service area .	Switch to a Medicare Prescription Drug Plan.	If the plan is informed before the move, the chance to switch plans begins the month before the month of the move and continues for 2 full months after the move. If the plan is informed after the move, the chance to switch plans begins the month the plan is informed, plus 2 more full months.
Moved to a new address that's still in the plan's service area, but there are new plan options in the new location.		
Moved back to the United States after living outside the country.	Join a Medicare Prescription Drug Plan.	The chance to join lasts for 2 full months after the month of the move back to the U.S.
Just moved into, currently live in, or just moved out of an institution (such as a skilled	• Join a Medicare Prescription Drug Plan. • Switch from a current	The chance to join, switch, or drop coverage lasts if they live in the institution and for 2 full months

nursing facility or long-term care hospital).	plan to another Medicare Prescription Drug Plan. • Drop the Medicare prescription drug coverage.	after the month they move out of the institution.
Released from jail.	Join a Medicare Prescription Drug Plan.	The chance to join lasts for 2 full months after the month they're released from jail.
Changes that Cause the loss of Current Coverage		
If this describes your client	**Then they can**	**At this time**
No longer eligible for Medicaid.	Join Medicare Prescription Drug Plan. Switch from your current plan to Medicare Prescription Drug Plan. Drop the Medicare prescription drug coverage.	The chance to change lasts for 2 full months after the month they find out they're no longer eligible for Medicaid.
Leaves coverage from an employer or union (including COBRA coverage).	Join a Medicare Prescription Drug Plan.	The chance to join lasts for 2 full months after the month coverage ends.
Involuntarily loses other drug coverage that is as good as Medicare drug coverage (creditable coverage), or the other coverage changes and is no longer creditable.	Join a Medicare Prescription Drug Plan.	The chance to join lasts for 2 full months after the month of the loss of creditable coverage or is notified of the loss of creditable coverage, whichever is later.
Has drug coverage through a Medicare Cost Plan and they leave the plan.	Join a Medicare Prescription Drug Plan.	The chance to join lasts for 2 full months after the month they drop the Medicare Cost Plan.
Drops their coverage in a Program of All-Inclusive Care for the Elderly (PACE) plan.	Join a Medicare Prescription Drug Plan.	The chance to join lasts for 2 full months after the month the PACE plan is dropped.
Chance to get other coverage		
If this describes your client	**Then they can**	**At this time**
Chance to enroll in other coverage offered by an employer or union.	Drop Medicare Prescription Drug Plan to enroll in the private plan offered by your employer or union.	Whenever an employer or union allows changes in the plan.
Has or is enrolling in other drug coverage as good as Medicare prescription drug coverage (such as TRICARE or VA coverage).	Drop the Medicare Prescription Drug Plan.	Anytime.
Enrolls in a Program of All-Inclusive Care for the Elderly (PACE) plan.	Drop the Medicare Prescription Drug Plan.	Anytime.
Lives in the service area of one or more Medicare Prescription Drug Plans with an overall quality rating of 5 stars.	Join a Medicare Prescription Drug Plan with an overall quality rating of 5 stars.	One time during the year for which the plan they are joining has the overall quality rating of 5 stars.

Changes in the contract with Medicare		
If this describes your client	**Then they can**	**At this time**
Medicare takes an official action (called a "sanction") because of a problem with the plan that affects the enrollee.	Switch from the Medicare Prescription Drug Plan to another plan.	The chance to switch is determined by Medicare on a case-by-case basis.
The plan's contract ends (terminates) during the contract year. The Medicare Advantage Plan, Medicare Prescription Drug Plan, or Medicare Cost Plan's contract with Medicare isn't renewed for the next contract year.	Switch from the Medicare Prescription Drug Plan to another plan. Join another Medicare Prescription Drug Plan.	The chance to switch starts 2 months before and ends 1 full month after the contract ends. Between October 15 and the last day in February.
Changes due to other special situations		
Eligible for both Medicare and Medicaid.	Join, switch, or drop Medicare prescription drug coverage.	Anytime.
Qualifies for Extra Help paying for Medicare prescription drug coverage.	Join, switch, or drop Medicare prescription drug coverage.	Anytime.
Enrolled in a State Pharmaceutical Assistance Program (SPAP) or lose SPAP eligibility.	Join either a Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage.	Once during the calendar year.
Has a severe or disabling condition, and there is a Medicare Chronic Care Special Needs Plan (SNP) available that serves people with this condition.	Join a Medicare Chronic Care SNP.	They can join anytime, but once they join, the chance to make changes using this SEP ends.
Enrolled in a Special Needs Plan (SNP) and no longer has a condition that qualifies as a special need that the plan serves.	Switch from the SNP to a Medicare Prescription Drug Plan.	They can choose a new plan starting from the time of the loss of the special need's status, up to 3 months after the SNP grace period ends.
Joined a plan, or chose not to join a plan, due to an error by a federal employee.	• Join a Medicare Advantage Plan with drug coverage or a Medicare Prescription Drug Plan. • Switch from the current plan to another Medicare Prescription Drug Plan. • Drop the Medicare prescription drug coverage.	The chance to change coverage lasts for 2 full months after the month a notice of the error is received from Medicare.

Part D Late Enrollment Penalty

If a Medicare Part D beneficiary joins a Medicare Part D prescription drug plan after their first eligible for Medicare coverage, or they were without Medicare drug coverage of more than 63 days and they did not have any other "creditable prescription drug

coverage" they may be assessed a Medicare Part D late-enrollment premium penalty (LEP). The penalty is an additional amount they will pay every month for Part D coverage along with their monthly premium.

Creditable Drug Coverage Defined

"Creditable drug coverage" is any prescription coverage that is at least as good as basic Medicare Part D prescription drug coverage and if the Medicare beneficiary has some form of creditable coverage , they will not need to join a Medicare Part D plan and will not be assessed a late-enrollment penalty if they someday choose to add Part D prescription drug coverage.

Some examples of creditable drug coverage include VA (Veterans Administration) drug coverage, TRICARE, and possibly employer/union drug coverage. (The beneficiary should check with their employer/union health administrator to verify their drug coverage is "creditable" for purposes of Medicare Part D).

How The Part D Late Enrollment Penalty (LEP) Is Calculated

The Medicare Part D late-enrollment penalty is calculated as the number of months an individual is without some form of "creditable" prescription drug coverage multiplied by 1% of the national base premium ($36.78, up from $34.70 in 2024) or $4.40 per month in addition to the Medicare drug plan premium.

You can think of this example calculation as either:

> 1% for each month - so 12 months would be 12% - multiplied by the national base premium.
>
> 12% x $36.78 = $4,4136 $4.40 (rounded
>
> or
>
> The number of months times 1% of the national base premium:
>
> 12 x $0.3678 ($36.78 x1% = $4.4136 or $4.40 (rounded

Both calculations come to the same result.

It's important to remember the late enrollment penalty is permanent and the Medicare Part D beneficiary will pay the penalty (adjusted each year for the annual base Medicare Part D premium) as long as they have Medicare drug coverage (see Table 14.15).

Table 14.15
Medicare Part D National Base Premium

2025	$36.78	2015	$33.13
2024	$34.70	2014	$32.42
2023	$32.74	2013	$31.17
2022	$33.37	2012	$31.08
2021	$33.06	2011	$32.34
2020	$32.74	2010	$31.94
2019	$33.19	2009	$30.36
2018	$35.02	2008	$27.93
2017	$35.63	2007	$27.35
2016	$34.10	2006	$32.20

The Cost of Waiting

In 2025, the maximum late-enrollment penalty can reach as high as $984 (up from $878 in 2024) per year-paid in addition to a beneficiary's Part D plan premium. It is possible that the Medicare Part D beneficiary could have a late-enrollment penalty reaching as high as an additional $82.00 per month that must be paid in addition to their 2025 Medicare Part D or Medicare Advantage plan premium.

Inflation Reduction Act, 2022

President Jo Biden signed into law the sweeping $750 billion Inflation Reduction Act (IRA) of 2022 that into law that includes several provisions affecting prescription drug costs for Medicare beneficiaries. Here is a year-by-year summary of some of the top Medicare Part D plan changes:

Beginning 2023

- **Drug price increases tied to inflation:** Drug companies will be required to pay rebates to Medicare if retail drug prices (for Part B and Part D drugs) rise faster than inflation (CPI-U).
- **No co-pay vaccines:** Medicare Part D beneficiaries will have no cost sharing for vaccines that are recommended by the Advisory Committee on Immunization Practices (ACIP)), such as Shingles and Pneumonia vaccines.
- **$35 insulin:** Insulin included on a Medicare Part D plan formulary will have a $35 monthly co-pay and will not be subject to the plan's deductible. In addition, beginning July 1, 2023, insulin furnished through Medicare Part B durable medical equipment (DME), will also have a monthly co-pay of no more than $35. This new provision is similar to the current Medicare Part D Senior Savings where 2021 and 2022 Medicare Part D plans had the option to offer some select forms of insulin for a copay of $35 or less.

Beginning 2024

- **No Cost for Part D Drugs after reaching 2024 TrOOP**: Beginning in CY 2024, cost-sharing for Part D drugs will be eliminated for beneficiaries in the catastrophic phase of coverage.
- **Partial LIS – Becomes Full LIS:** Beginning in CY 2024, the Low-Income Subsidy program (LIS) under Part D will be expanded so that beneficiaries who earn between 135 and 150 percent of the federal poverty level and meet statutory resource limit requirements will receive the full LIS subsidies that, prior to 2024, were available only to beneficiaries earning less than 135 percent of the federal poverty level; these subsidies provide for $0 premiums and low-cost, fixed copayments for covered prescription drugs.
- During CY 2024, Part D plans must not apply the deductible to any Part D covered insulin product and must charge no more than $35 per month's supply of a covered insulin product in the initial coverage phase and the coverage gap phase.
- **Insulin Costs**. During CY 2024, Part D plans must not apply the deductible to an adult vaccine recommended by the Advisory Committee on Immunization Practices and must charge no cost-sharing at any point in the benefit for such vaccines.
- **Eliminate Large Part D Premium Increases**: Beginning in CY 2024, the annual growth in the Base Beneficiary Premium will be capped at 6 percent. The Base Beneficiary Premium for Part D is limited to the lesser of a 6 percent annual increase, or the amount that would otherwise apply under the prior methodology had the IRA not been enacted.

Beginning 2025

- **No cost for Part D formulary drugs after reaching $2,000 out-of-pocket cap:** Medicare Part D beneficiaries will have a $2,000 maximum cap on out-of-pocket spending for Part D formulary drugs (RxMOOP). In 2025, the $2,000 RxMOOP should be reached when a person purchases Medicare Part D formulary drugs with a retail value totaling $6,335. The $2,000 RxMOOP can increase every year like other Medicare Part D parameters*.
- **Change to Medicare Part D plan designs:** With the addition of the $2,000 RxMOOP, Medicare Part D plans would have only two parts of coverage (or less): (1) the Initial Deductible (if any) and (2) the Initial Coverage Phase that would continue until December 31 of the plan year - or cease when the plan member's out-of-pocket spending reached $2,000 and the person has no additional costs for Part D formulary drugs. Medicare Part D plans would no longer have the Part D Coverage Gap (Donut Hole with the accompanying Donut Hole Discount) and Catastrophic Coverage phases.
- **A person's drug costs can be evenly spread over the year:** Medicare Part D plans are required to provide plan members with an option allowing people to spread their monthly prescription drug costs evenly over the year.

Beginning 2026

- **Federal government drug price negotiation:** In 2026, HHS will be allowed to negotiate prices for 10 Medicare Part D drugs (single-source drugs with the highest Medicare Part D spending over the past 12 months).
- **Insulin copay may be less than $35:** Insulin covered by a Medicare Part D plan will cost the lesser of the $35 co-pay or 25% of the retail price (as negotiated by the plan or by the government** (HHS)).

In 2027

- **Federal government drug price negotiation:** HHS will negotiate prices for 15 additional Medicare Part D drugs with high spending.

In 2028

- **Federal government drug price negotiation:** HHS will negotiate prices for 15 Medicare Part D and Part B drugs with high spending.

In 2029 (or subsequent year)

- **Federal government drug price negotiation:** HHS will negotiate prices for 20 additional Medicare Part D and Part B drugs with high spending.

*1860D-2(b)(6) Annual percentage increase - The annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered part D drugs in the United States for part D eligible individuals, as determined by the Secretary for the 12-month period ending in July of the previous year using such methods as the [HHS] Secretary shall specify.

** 1860D-2(b)(9)(D) APPLICABLE COPAYMENT AMOUNT. In this paragraph, the term 'applicable copayment amount' means, with respect to a covered insulin product under a prescription drug plan or an MA–PD plan dispensed.

- During plan years 2023, 2024, and 2025, $35; and
- During plan year 2026 and each subsequent plan year, the lesser of:
    - $35;
    - an amount equal to 25 percent of the maximum fair price established for the covered insulin production accordance with part E of title XI [PRICE NEGOTIATION PROGRAM TO LOWER PRICES FOR CERTAIN HIGH-PRICED SINGLE SOURCE DRUGS];or
    - an amount equal to 25 percent of the negotiated price of the covered insulin product under the prescription drug plan or MA–PD plan.

Further Reading

CMS, Medicare Plan Finder;
https://www.medicare.gov/plan-compare/#/?lang=en

CMS Releases 2024 Projected Medicare Part D Premium, July 31, 2003
CMS Releases 2024 Projected Medicare Part D Premium and Bid Information | CMS

Kaiser Family Foundation, "*An Overview of Medicare Part D Prescription Drug Plans*,"
https://www.kff.org/medicare/issue-brief/medicare-part-d-in-2024-a-first-look-at-prescription-drug-plan-availability-premiums-and-cost-sharing/

Q1 Group LLC, "*2024 Medicare Part D Outlook,*"
https://q1medicare.com/PartD-The-2023-Medicare-Part-D-Outlook.php

CMS Fact Sheet – 2024 Medicare Advantage and Part D Star Ratings
10.13.23 Fact Sheet - 2024 Medicare Advantage and Part D Ratings (cms.gov)

Q1 Group LLC, "*Medicare Part D 2023 State Highlights*,"
https://q1medicare.com/PartD-2023-MedicarePartD-PlanOverviews.php

2022 Inflation Protection Act
https:// www.congress.gov/bill/117th-congress/house-bill/5376/text

Kaiser Family Foundation, "A Current Snapshot of the Medicare Part D Prescription Drug Benefit," Published October 9, 2024;
https://www.kff.org/medicare/issue-brief/a-current-snapshot-of-the-medicare-part-d-prescription-drug-benefit/#:~:text=Changes%20to%20the%20Medicare%20Part,Medicare's%20share%20of%20these%20costs.

Chapter 14
Review Questions

1. Which of the following enacted by Congress created Medicare Part D?

( ) A. The Balanced Budget Act 1997
( ) B. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003
( ) C. Deficit Reduction Act Social Security Administration 2005
( ) D. Social Security Act of 1965

2. Who is responsible for administering the Medicare Part D program?

( ) A. Centers for Medicare and Medicaid (CMS)
( ) B. Department of the Elderly and Consumer Affairs
( ) C. Social Security Administration
( ) D. Department of Health and Human Services

3. What will be the Part D deductible in 2025?

( ) A. $342.00
( ) B. $1,632
( ) C. $240.00
( ) D. $590.00

4. For 2025, what will be the Medicare Part D annual out-of-pocket spending limit?

( ) A. $8,000
( ) B. $2,000
( ) C. Unlimited
( ) D. $14,250

5. The Part D late-enrollment penalty (LEP) is calculated at what percent of the annual national base Medicare Part D monthly premium?

( ) A. 10%
( ) B. 5%
( ) C. 3%
( ) D. 1%

CHAPTER 15

MEDICARE SUPPLEMENTAL INSURANCE POLICIES

Overview

Medicare Supplemental Insurance Policies, which private insurance companies sell, are a vitally important product for seniors and other beneficiaries who choose Medicare's original Fee-for-Service (FFS) program. Year after year, beneficiary out-of-pocket costs for Medicare's FFS coverage increase. To assist in paying for these gaps in coverage– deductibles, copayments, and coinsurance amounts, beneficiaries purchase a Medicare Supplemental Insurance policy, also known as "Medigap" policies.

This chapter will examine the background and legislative intent of Medicare (Medigap) Supplement policies, the various types of Medigap policy plans, their features, benefits, premium costs, and enrollment periods. The end of the chapter will examine the changes to Medigap policies that took effect on January 1, 2021.

Learning Objectives

Upon completion of this chapter, you will be able to:

- Review the background and legislative intent of Medigap policies.
- List the various categories of Medigap policies.
- Identify the 10 standardized benefit packages: and
- Assist your clients in selecting a Medigap policy.

Background

Medicare Supplement (also known as "Medigap") is a key source of supplemental coverage for Medicare beneficiaries. Seniors purchase Medigap coverage to protect themselves from high out-of-pocket costs not covered by Medicare, budget for medical expenses, and avoid the confusion and inconvenience of handling complex bills from health care providers.

Medigap Legislation

Over the last 30 years, Medicare Supplement plans have undergone major changes to benefit designs. First, the provisions of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) required that policies sold after July 1992 conform to 1 of 10 uniform benefit packages, known among Medicare Supplemental plans as Plans A through J. Then in 2003, the Medicare Modernization Act (MMA) required elimination of prescription drug benefits from Medicare Supplement coverage, authorized 2 new plans (Plans K and L) with cost sharing features, and encouraged the development of standardized benefit designs with additional cost sharing features.

Further changes to standardized plans occurred in 2008 with the passage of the Medicare Improvements for Patients and Providers Act (MIPPA) and included:

- Elimination of the at-home recovery benefit in favor of a new hospice benefit (described below).
- Addition of a new core hospice benefit that covers the cost sharing under original Medicare for palliative drugs and inpatient respite care.
- Removal of the preventive care benefit in recognition of the increased original Medicare coverage under Part B.
- Introduction of 2 new Medicare Supplement policies (Plans M and N) with increased enrollee cost-sharing features.
- Elimination of several standardized plans (Plans E, H, I, J and J with high deductible) that became duplicative or unnecessary due to benefit design changes.

All Medicare Supplement plans are "guaranteed renewable" regardless of when they were purchased. Therefore, some policyholders continue to maintain plans with previous benefits even though the plans can no longer be sold.

Most Medicare Supplement plans cover enrollees' Part A deductible and Part B coinsurance. Two plans—standardized plans C and F— offer full coverage for the Part B deductible.

Plans F and G can also be sold as a high-deductible plan. These plans also cover Part B coinsurance and co-payment amounts, as do most, but not all, standardized plans.

Plans K and L do not cover the Medicare Part B deductible and cover a portion of enrollees' Part B coinsurance. However, there is a limit on enrollees' annual out-of-pocket costs for Medicare eligible expenses —$7,220 for Plan K and $3,610 for Plan L in 2025. New Plans M and N entered the market in June of 2010. Plan M covers half of Part A deductible and does not cover Part B deductible. Plan N covers all the Part A deductible and does not cover the Part B deductible. Plan N also includes cost-sharing amounts of up to $20 for certain physician visits and up to $50 for certain emergency department visits.

Medicare SELECT plans are identical to standardized Medicare Supplement plans but require policyholders to use provider networks to receive the full insurance benefits. For this reason, Medicare SELECT plans generally cost less than other Medicare Supplement plans.

In April 2015, Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This new law provided that beginning on January 1, 2020, Medicare Supplement insurance carriers can no longer sell Medicare Supplement plans covering the Part B deductible to individuals who are "newly eligible" for Medicare. People who attained aged 65 before January 1, 2020, and those who were eligible for Medicare due to disability before that date, continued to have access to Plans C and F, which are the only standardized plans currently available for sale that cover the Part B deductible.

Waivered States

Three states (Massachusetts, Minnesota, and Wisconsin) offer standardized Medicare Supplement plans but are exempt from the OBRA 1990 standardized plan provisions (and subsequent revisions under the MMA or MIPPA). Standardized plans may therefore be changed by waivered states without federal approval. Individuals who purchase Medicare Supplement plans in 1 of these 3 states may keep their plans if they move to other states.

Pre-Standardized Plans

Historically, Medicare Supplement changes have been phased in for new purchasers, and existing policyholders were allowed to retain their pre-standardized policies. Although OBRA 1990 prohibited the sale of new pre-standardized plans, some enrollees still have pre-standardized policies.

Medicare Supplement Enrollment

In 2022 (latest data available), Medicare Supplement insurance coverage continued to grow and reached a record 41.4% of all Medicare fee-for-service enrollees (see Table 15.1). However, as enrollment in traditional, FFS Medicare has decreased (shrinking by more than a million enrollees in 2021-22 alone), national Medicare Supplement enrollment also fell by 1.9% in 2022 (see Table 15.1).

The updated data demonstrates that the share of enrollees in Medicare Supplement has been steadily growing in recent years. This growth continued, and even accelerated, in 2022 when the proportion of original Medicare enrollees with Medicare supplement increased from 40.9% to 41.4%. The enrollment in the Medicare program is projected to continue growing rapidly through 2030, and further growth in Medicare Supplement enrollees is likely.

Nationwide, Medicare Current Beneficiary Survey (MCBS) estimates show that 57% of all non-institutionalized Original Medicare enrollees without any additional coverage (i.e., Medicare Advantage, Medicaid, Veterans Affairs coverage, employer-provided

insurance, retiree drug subsidy plan, self-purchased specialty plan, etc.) chose Medicare Supplement policies in 2021.

Table 15.1
Trends in National Medicare Supplement Enrollment, 2017 – 2022

Statistic	Year				
	2018	2019	2020	2021	2022
Enrollment Report to NAIC	13,546429	14,013.086	13,900,107	14,077,889	13,790,813
Enrollment reported to California DMHC	444,391	469,792	495,681	514,179	528,839
Total National Medicare Supplement Enrollment	13,990,820	14,482,878	14,395,788	14,592,068	14,319,652
Annual percent change in total national Medicare Supplement Enrollment, %	3.7%	3.5%	-0.6	1.4%	1.9%

Source: AHIP Center for Policy and Research analysis of the NAIC Medicare Supplement Insurance Experience Exhibits, and of the California DMHC Enrollment Summary Reports, 2017-2022. 202402-AHIP_MedicareSuppCvg-v05.pdf (ahiporg-production.s3.amazonaws.com)

Demographic Characteristics

The demographic characteristics of Medicare Supplement enrollees are based on the Medicare Current Beneficiary Survey (MCBS) 2020 data, which is the latest year for which data are available.

- Gender: Across the country, a majority (56%) of Medicare Supplement enrollees in 2020 were women. This gender distribution did not change from the previous year.
- Age: Medicare enrollees with Medicare Supplement insurance were older than the general Medicare population: 41% of Medicare Supplement policyholders were 75 years old or older compared with 37% for all Medicare enrollees (see Table 15.2)

Income and Financial Security

A significant number of Medicare Supplement policyholders were individuals with lower incomes:

- 8% had annual household incomes below $20,000,
- 13% had annual household incomes below $30,000,
- 21% had annual household incomes between $30k and $49.9k,
- 22% had annual household incomes between $50k and $79.9k; and

- 36% had annual household incomes of $80k or more.

Income range of Medigap policyholders in urban areas:

- 7% had annual household incomes below $20,000,
- 12% had annual household incomes below $30,000,
- 20% had annual household incomes between $30k and $49.9k,
- 21% had annual household incomes between $50k and $79.9k; and
- 40% had annual household incomes of $80k or more.

Income range of Medigap policyholders in rural areas:

- 12% had annual household incomes below $20,000,
- 17% had annual household incomes below $30,000,
- 25% had annual household incomes between $30k and $49.9k,
- 22% had annual household incomes between $50k and $79.9k; and
- 23% had annual household incomes of $80k or more.

Original Medicare enrollees with Medicare Supplement coverage were nearly 3 times less likely to have problems paying medical bills compared to enrollees without Medicare Supplement policies.

Table 15.2
Age Distribution of Medicare Supplement Policyholders, by Geographical Location 2021

	Age Groups			
	Younger than 65	**65 – 74 Years**	**75 – 84 Years**	**85 and Older**
All Medicare	12%	51%	27%	10%
All Medicare Supplement	2%	57%	31%	10%
Urban Medicare Supplement	2%	58%	30%	10%
Rural Medicare Supplement	2%	53%	34%	11%

Source: Source: Medicare Current Beneficiary Survey Limited Data Set Files, 2021 (CMS). Note: Calculations based on responses by non-institutionalized Medicare enrollees reporting income. The percentages in this table may not sum to 100 due to rounding
202402-AHIP_MedicareSuppCvg-v05.pdf (ahiporg-production.s3.amazonaws.com)

Geography

Data shows that 24% of Medicare Supplement policyholders lived in non-metropolitan areas (which, for the purpose of this report, includes any area with an urban cluster of less than 50,000 people) in 2021.

Rural Medicare Supplement policyholders had substantially fewer financial resources than urban policyholders: only 23% of rural Medicare Supplement policyholders had

household incomes of $80,000 or more compared to 40% for urban Medicare Supplement policyholders.

Marital Status

Many Medicare Supplement enrollees live without a partner and thus have less robust support networks to rely on in case of financial or health problems: 39% of Medicare Supplement enrollees were widowed, divorced, separated, or never married in 2021. Medicare Supplement coverage provides an important source of security for this potentially vulnerable group.

Companies Offering Coverage

As of December 2022, 9% of companies offering standardized Medicare Supplement policies covered individuals in 41 or more states or territories, 22% of companies covered individuals in 26 to 40 states or territories, 11% covered individuals in 11 to 25 states or territories, and 18% of companies covered individuals with standardized Medicare Supplement plans in 2 to 10 states or territories. In addition, 40% of all Medicare Supplement companies had standardized policies in force in a single state or territory (see Table 15.3)

Table 15.3
Distribution of Medigap Companies with Standardized Medigap Policies in Force, by Market Size, December 2022

Number of States or Territories	Percent of Companies
41 or more	9%
26–40	22%
11–25	11%
2–10	18%
1	40%

Source: AHIP Center for Policy and Research analysis of the
NAIC Medicare Supplement Insurance Experience Exhibit, for the Year Ended Dec. 31, 2022
202402-AHIP_MedicareSuppCvg-v05.pdf (ahiporg-production.s3.amazonaws.com)

Eighty-five companies had Medicare SELECT policies in force for about 460,000 Medicare enrollees on December 31, 2022. Companies with Medicare SELECT policies in force were located across the country in 41 states on December 31, 2021.

Overall, the percentage distribution of reporting companies with standardized Medicare Supplement policies in force by plan type experienced only minor changes in the last 5 years (see Table 15.4). In 2022, the most commonly offered plans were Plan F (85%), Plan A (77%), and Plan G (75%).

In 2021, 75% of Medicare Supplement insurance providers had Plan G policies in force vs. 73% in 2020, while 67% of insurance providers had Plan N policies in force in 2021 vs. 64% in 2020. Plan B and Plan C that experienced a sustained decline for the last several years broke that trend in 2021: the share of companies offering them remained unchanged from 2020 53% for Plan B and 69% for Plan C.

In accordance with previous trends, Plan N continued to increase in popularity and rose from 67% to 68% of insurance providers with policies in force. Plan A, Plan B, and Plan C continued a slow, but sustained decline of previous several years: the share of companies offering them in 2022 compared to the prior year decreased from 79% to 77% for Plan A, from 53% to 51% for Plan B, and from 69% to 68% for Plan C.

Table 15.4
Percent of Companies with Standardized Medigap Policies in Force, by Plan Type, 2018–2022

Companies					
Plan Type	**2018**	**2019**	**2020**	**2021**	**2022**
A	81%	83%	82%	79%	77%
B	55%	54%	53%	53%	51%
C	74%	72%	69%	69%	68%
D	42%	42%	47%	45%	46%
E	24%	23%	22%	21%	20%
F	85%	85%	85%	86%	85%
G	66%	70%	73%	75%	75%
H	21%	21%	20%	20%	19%
I	19%	18%	18%	17%	17%
J	22%	22%	21%	20%	20%
K	15%	15%	15%	15%	15%
L	14%	15%	15%	14%	13%
M	9%	9%	8%	9%	8%
N	59%	62%	64%	67%	68%
Waiver State Plans	34%	35%	35%	33%	35%

Source: AHIP analysis of the National Association of Insurance Commissioners' (NAIC) Medicare Supplement Insurance Experience Exhibit, for the Year Ended December 31, 2022
202402-AHIP_MedicareSuppCvg-v05.pdf (ahiporg-production.s3.amazonaws.com)

Medicare Supplement Policies in Force

According to the NAIC data, almost all of the Medicare Supplement policies in force on December 31, 2022, were standardized plans, at 98.9%. Pre-standardized plans, which were no longer sold after July 1992, account for only 1.1% of all Medicare Supplement policies (see Table 15.5).

Table 15.5
Number of Individuals with Standard and
Pre-standard Medigap Plans, as Reported to the NAIC, December 2022

Plans	Policies	Percent
Standard Medigap	13,635,714	98.9%
Pre-Standard Medigap	155,099	1.1%
All Medigap	13,790,813	100%

Source: AHIP analysis of the National Association of Insurance Commissioners' (NAIC) Medicare Supplement Insurance Experience Exhibit, for the Year Ended December 31, 2022
202402-AHIP_MedicareSuppCvg-v05.pdf (ahiporg-production.s3.amazonaws.com)

Among enrollees with Medicare Supplement standardized plans, Plan F retained its position as the plan with by far the highest number of enrollees. However, it continued to rapidly lose its market share, declining from 49% in 2019 to 39% in 2022. On the other hand, Plan G similarly continued its previous fast growth, increasing from 22% of enrollment in 2019 to 36% in 2022 (see Tables 15.6 and 15.7).

Table 15.6
Distribution of Enrollment by Standardized Plan Type, 2019-2022

Plan Type	2019	2020	2021	2022
A	1%	1%	1%	1%
B	2%	1%	1%	1%
C	5%	4%	3%	3%
D	1%	1%	1%	1%
E	<0.5%	<0.5%	<0.5%	<0.5%
F*	49%	46%	41%	39%
G**	22%	27%	32%	36%
H	<0.5%	<0.5%	<0.5%	<0.5%
I	1%	<0.5%	<0.5%	<0.5%
J	3%	2%	2%	2%
K	1%	1%	1%	<0.5%
L	<0.5%	<0.5%	<0.5%	<0.5%
M	<0.5%	<0.5%	<0.5%	<0.5%
N	10%	10%	10%	10%
Waiver State Plans	6%	6%	6%	6%

Source: AHIP analysis of the National Association of Insurance Commissioners' (NAIC) Medicare Supplement Insurance Experience Exhibit, for the Year Ended December 31, 2022
https://www.ahip.org/documents/202301-AHIP_MedicareSuppCvg-v03.pdf

Despite the variety of standardized Medicare Supplement plans in the market, 3 plan types (F, G, and N) accounted for more than 85% of the total enrollment. At the same time, 5 standardized Medicare Supplement plans with the lowest enrollment (E, H, I, L, and M) combined added up to less than 1% of all standardized policies (see Tables 15.6 and 15.7).

Table 15.7
Change in Medigap Enrollment, Standardized Policies, 2018–2022

Plan Type	Enrollment				Change in Enrollment 2021-2022	Percent change 2021-2022
	2019	2020	2021	2022		
A	107,919	99,809	92,828	96,899	4,071	4%
B	206,587	182,388	181,741	159,437	-22,304	-12%
C	624,321	542,229	478,702	401,964	-76,738	-16%
D	123.117	125,899	151,327	124,701	-26,628	-18%
E	51,203	45,485	38,371	33,452	-4,919	-13%
F	6,804,076	6,238,576	5,749712	5,332,340	-417,372	-7%
G	3,067,424	3,727,474	4,513,504	4,856256	342,752	8%
H	31,014	27,259	21,891	18,858	-3,033	-14%
I	74,338	56,501	46,350	40,096	-6,254	-13%
J	371,432	332,461	300,074	269,401	-30,673	-10%
K	80,527	76,331	69,866	64,054	-5,812	-8%
L	42,546	38,949	33,648	30,612	-3,036	-9%
M	4,151	3,782	4,546	4,469	-77	-2%
N	1,359,949	1,362,694	1,384,304	1.377,952	-6,352	0%
Waivered State Plans	857,757	849,518	840,834	825,223	-15,611	-2%
Pre-Standardized Plans	206,725	190,752	170,191	155,099	-15,092	-91%
Total	**14,013,086**	**13,900,107**	**14,077,889**	**3,790,813**	**-287,076**	**2%**

Source: AHIP analysis of the National Association of Insurance Commissioners' (NAIC) Medicare Supplement Insurance Experience Exhibit, for the Year Ended December 31, 2022
202402-AHIP_MedicareSuppCvg-v05.pdf (ahiporg-production.s3.amazonaws.com)

Fast Growing Medicare Supplement Plans

In 2022, the only plans that posted the enrollment increases were plans G and A.

In the continuation of a multi-year trend of rapid growth, the enrollment in Plan G, which covers all Medicare deductible and coinsurance amounts except the Part B deductible, increased by 8% from 2021 to 2022, by 343,000 enrollees. Plan G also has a high-deductible option, the deductible for which was $2,490 in 2022. As was true in the 3 previous years, Plan G posted the fastest rate of growth in 2022 in both relative and absolute terms.

In another sign of growth, Plan A posted an enrollment growth of 4% in 2022, reversing several years of declining enrollment. Plan A is a basic Medicare Supplement Insurance plan with low premiums.

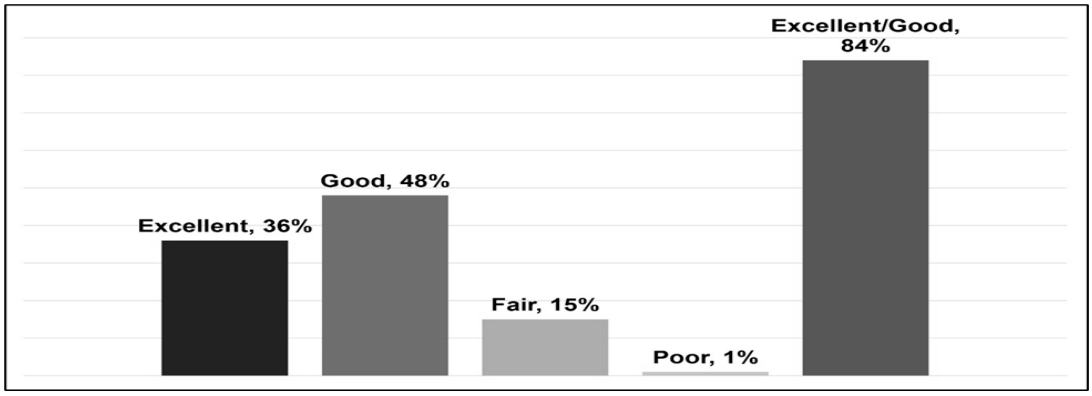
The enrollment in the largest Medicare Supplement plan, Plan F, decreased by 7% in 2022 compared to the previous year. The regular version of Plan F provides coverage for Medicare deductibles and coinsurance amounts. Life Plan G and Plan F also includes a high-deductible option that allows for a deductible amount of$2,490 (in2022) before the policy can begin paying benefits.

Similarly, the enrollment in several other Medicare Supplement plan types continues to decline. Double-digit enrollment declines occurred in Plan D (-18%), Plan H (-14%), Plan E (-13%), Plan I (-13%), Plan B (-12%), and Plan J (-10%).

Consumer Satisfaction with Medigap Policies

Medicare beneficiaries overwhelmingly value their Medigap insurance. In a 2023 survey conducted by Global Strategy, on behalf of American Health Insurance Plans (AHIP), beneficiaries of Medicare supplemental insurance are overwhelmingly satisfied with their plans and the coverage. Most seniors on these plans see their supplemental insurance as good value that protects their financial security (see Table 15.8).

Table 15.8
Eight Out of Ten Say that Medigap is an Excellent or Good Value



Source: AHIP Seniors' Satisfaction with their Medicare Supplemental Insurance Coverage; released February 10, 2023
PowerPoint Presentation (ahiporg-production.s3.amazonaws.com)

Other key findings:

- Seniors with Medicare Supplement coverage continue to be highly satisfied with their coverage, including its benefits, services, and the expenses it covers.
- Medicare Supplement coverage ensures seniors receive high-quality care, allows them to choose the doctors and specialists they know and trust, and makes it easier for them to deal with bills and paperwork.
- Medicare Supplement's guaranteed, renewable coverage and affordable cost provides peace of mind for seniors, who worry about their financial security and physical well-being if they were to lose their Medicare Supplement coverage.

Standard Medigap Plans

As mentioned earlier, the federal government regulates Medigap insurance policies–and the insurance companies may not offer Medigap policies that duplicate Medicare's own coverage. Your client may choose from among the 10 currently available standard Medigap plans. The standard policies are specifically tailored to Medicare coverage, each one filling a certain number of Medicare's gaps (see Table 15.12).

Not every insurer offers every plan, and only the benefits included in the plans are standardized. Other important aspects–premium increases and pre-existing illness exclusions–vary from policy to policy and require careful comparison shopping.

When considering a Medigap policy, the beneficiary should see how many of the gaps in Medicare payments they can fill within the constraints of their own budget. Of course, the broader their coverage in a Medigap policy, the higher their cost.

Although the benefits are standardized, the cost of a standard policy varies widely from company to company. So, they must determine which benefit plan best suits their needs and which company offers which plan at the best price. Then examine the other elements of each policy, such as premium increases and pre-existing exclusions, before determining which Medigap policy is best for them.

Note: The following three states have their own standardized Medigap policies:

- Massachusetts (for specific information, you can visit: https://www.medicare.gov/supplement-other-insurance/compare-medigap/massachusetts/medigap-massachusetts.html;
- Minnesota (for specific information, you can visit: https://www.medicare.gov/supplement-other-insurance/compare-medigap/minnesota/medigap-minnesota.html; and
- Wisconsin (for specific information, you can visit: https://www.medicare.gov/supplement-other-insurance/compare-medigap/wisconsin/medigap-wisconsin.html.

Basic Benefits

The basic benefits that are included in all standard Medigap plans begin by offering the same basic benefits, including coverage of:

- Hospital coinsurance amounts under Medicare Part A.
- 365 days of hospital coverage after Medicare coverage ends.
- Some or all of the cost of covered blood transfusions.
- Some or all of the Medicare Part B coinsurance amount (the 20% of Medicare-approved amounts that Medicare Part B does not pay); and
- New Hospice benefit will provide a drug copay and inpatient respite care coinsurance. The modernized plans will now cover the expenses below as a core benefit:
    - $5 copay for outpatient prescription drugs for pain and symptom management; and
    - 5% of the Medicare-approved amount for inpatient respite care (short-term care given by another caregiver so the usual caregiver can rest). It does not include room and board.

Notice that these basic benefits are meant to close gaps in Medicare coverage, not to provide separate medical insurance. If Medicare does not cover hospitalization or medical treatment, a Medigap policy will not cover any of it either. The exception to this is those policies that cover foreign travel and some preventive care.

- *Inpatient Hospital Expenses:* For every benefit period, every plan pays all of the beneficiary's Medicare Part A coinsurance amounts through the first 90 days as an inpatient, plus the coinsurance amounts for any reserve days. After their reserve days are used up, every plan pays for the entire Medicare-approved hospital charges for an additional 365 days: and
- *Medical Expenses:* Every plan pays some of the 20% coinsurance amount Medicare Part B does not pay: Plans A through J pay the full Part B coinsurance amounts (until the Plan K yearly cap on out-of-pocket costs is reached); and Plan L pays 75% of most Part B coinsurance amounts (until the Plan L yearly cap is reached). The basic Medigap benefits do not include the Part B deductible or the 15% above the Medicare-approved amount that a doctor is allowed to charge if they do not accept assignment.

Medigap Plan A

Plan A provides the basic (core) benefits plus:

- Coverage for the Part A coinsurance amount is $419 per day for the 61st through the 90th day of hospitalization in each Medicare benefit period in 2025.
- Coverage for the Part A coinsurance amount is $838 per day for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days used in 2025.

- After all Medicare hospital benefits are exhausted. Coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during their lifetime. This benefit is paid either at the rate Medicare pays hospitals under its Prospective Payment System or another appropriate standard of payment.
- Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood or equivalent quantities of packed red blood cells per calendar year unless replaced in accordance with federal regulations; and
- 20% of Medicare-approved amount after the deductible, except in the outpatient setting.

Because of their limited benefits, Plan A policies are the cheapest. Plan A policies are most useful if the doctors who regularly treat the beneficiary accept the assignment of Medicare-approved amounts. The beneficiary can afford to pay for the uncovered costs of doctors who do not accept assignment but by whom they might have to be treated. Also, they must be able to afford Part A hospital insurance deductible. Keep in mind that because there is a separate hospital stay, they may have to pay for it more than once a year.

Medigap Plan B

Plan B provides the basic (core) benefits plus coverage for Medicare Part A inpatient hospital deductible of $1,676 in 2025.

If the beneficiary's doctors all accept assignments, but they cannot afford to pay for more than one hospital deductible in a year, Plan B may be marginally better for them than Plan A. However, it may be a bad bargain if they pay more than a few dollars a month more for Plan B than for Plan A.

The beneficiary should measure the yearly cost of a Plan B against the cost of a Plan A policy. If they are reasonably healthy–meaning they do not expect to have frequent hospitalizations–and the difference in premiums is more than 25% of the Part A Medicare Deductible ($1,676 in 2025), it is probably not worth the extra premium, and they should purchase a Plan A policy.

Not Covered in Medigap Plan B Policies:

- *Hospice Care Coinsurance or Copayment:* A hospice may be used as an alternative to hospitals or staying at home for terminally ill patients. There can be significant fees associated with hospice and end-of-life care and treatment. Medigap Plan B does not pay for any coinsurance or copayments related to hospice stay; and
- *Foreign Travel Emergency (Medicare coverage outside the U.S.):* Medicare does not cover healthcare coverage outside the United States. Medigap Plan B does not provide any assistance in this area either. Beneficiaries must pay for medical emergencies in foreign countries requiring treatment or travel in full out of pocket.

Medigap Plan C

Plan C provides the basic (core) benefits plus:

- Coverage for the Medicare Part A inpatient hospital deductible ($1,676 per benefit period in 2025).
- Coverage for the skilled nursing facility care coinsurance amount of $209.50 per day for 21 through 100 per benefit period in 2025.
- Coverage for Medicare Part B deductible ($257 per calendar year in 2025).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250.00 deductible.

If the beneficiary travels abroad frequently, this can be a valuable benefit. That said, there are some restrictions on coverage. Emergency medical care must begin within the first 60 days of each trip abroad; if they take long trips, this policy will not protect them after the first two months. There is a $50,000 lifetime maximum on these foreign travel medical benefits.
If they spend a good portion of each year abroad, they may need to purchase a separate–that is, non-Medigap–health insurance policy to cover them fully for treatment received outside the United States.

The cost for Plan C policies is considerably higher than for Plan A or B but runs about the same as for Plans D and E. **Note:** Plan C is the second most popular plan.

Not Covered in Medigap Plan C Policies:

- *At-home recovery costs.* After beneficiaries leave the hospital, they may still need to recuperate from surgery or other injuries. There may still be several health-related costs applied to the recovery effort. Doctors will often provide strict instructions to patients that they must follow to get back to normal. Often these instructions will incur additional expenses. Medigap Plan C policies do not cover these expenses that Medicare doesn't cover; and
- *Medicare Part B Excess Charges.* Another area where beneficiaries aren't covered with this plan deals with Medicare Part B excess charges. If a doctor doesn't accept assignments and charges for a bill that is over the limit of what Medicare will pay, then it's considered an excess charge. Medigap Plan C policies will not cover the charge, so beneficiaries must pay it themselves.

Note: Plan C was no longer for sale for newly eligible Medicare beneficiaries as of January 1, 2020. As part of the Medicare Access and Chip Reauthorization Act of 2016, supplemental plans that cover the Part B deductible can no longer be purchased after that time. If an individual has purchased a Part C plan before 2020, they will be allowed to keep their coverage.

Medigap Plan D

Plan D provides the basic (core) benefits plus:

- Coverage for the Medicare Part A inpatient hospital deductible ($1,676 per benefit period in 2025).
- Coverage for the skilled nursing facility care coinsurance amount ($209.50 per day for 21 through 100 per benefit period in 2025).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250.00 deductible; and
- Coverage for at-home recovery benefit. The at-home recovery benefit pays up to $1,676 per year for short-term at-home assistance with activities of daily living (which include: bathing, dressing, eating, transferring, toileting and continence) for those recovering from an illness, injury, or surgery. There are various benefit requirements and limitations.

Plan D pays for at-home recovery if the services performed are unskilled personal care–and pays for that only when it has been ordered by the beneficiary's doctor while the beneficiary is also receiving skilled home health care covered by Medicare. A Plan D policy pays up to $40 per visit, up to seven visits per week, but for no more than the number of Medicare-covered home health visits the beneficiary receives. There is a yearly maximum that each Plan D policy will pay.

With all these restrictions, plus the relatively low odds that beneficiaries will use Medicare-covered skilled at-home care, this coverage is of limited value. A Plan D policy is preferable to a Plan C only if available for about the same money. Other terms, such as pre-existing illness exclusions, are different.

Medigap Plan E

Medigap Plan E provides the basic (core) benefits plus:

- Coverage for the Medicare Part A inpatient hospital deductible ($1,676 per benefit period in 2025).
- Coverage for the skilled nursing facility care coinsurance amount ($209.50 per day for 21 through 100 per benefit period in 2025).
- 80% coverage for medically necessary emergency care in a foreign country up to a lifetime maximum of $50,000, after a $250.00 deductible; and
- Coverage for preventive medical care. The preventive medical care benefit pays up to $120 per year for such things as a physical examination, flu shot, serum cholesterol screening, hearing test, diabetes screenings, and thyroid function test.

Not Covered in Medigap Plan E Policies:

- *Hospice Care Coinsurance or Copayment:* Beneficiary may be required to pay up to $5 for each drug a hospice provides when they are getting hospice services in

their home and 5% of the Medicare-approved amount for each day of inpatient respite care (up to certain limits).

- *Medicare Part B Deductible:* They will need to cover the $257 yearly deductible in 2025.
- *Medicare Part B Excess Charges:* For doctors and other providers who don't accept assignment, they still must pay the difference between the Medicare-approved amount and either the provider's fee or the "limiting charge" (no more than 15% above the Medicare-approved amount) that applies for doctor's fees and many other Part B services; and
- *At-home Recovery* (Medicare-approved home health care to provide treatment ordered by beneficiary's doctor for an illness or injury.) The beneficiary pays $0 for Medicare-approved home health services and 100% for services not covered by Medicare.

Note: Effective June 1, 2010, Plan E was no longer sold. These plans now duplicate other plans because of the elimination of the at-home recovery and preventive benefits. If the beneficiary purchased a Medigap between July 31, 1992, and May 31, 2010, they could keep it, and their benefits will stay the same.

Medigap Plan F

Medigap Plan F provides the basic (core) benefits plus:

- Coverage for the Medicare Part A inpatient hospital deductible ($1,676 per benefit period in 2025).
- Coverage for the skilled nursing facility care coinsurance amount ($209.50 per day for 21 through 100 per benefit period in 2025).
- Coverage for the Medicare Part B deductible. ($257 per calendar year in 2025). 80% coverage for medically necessary emergency care in a foreign country up to a lifetime maximum of $50,000; after a $250.00 deductible and
- Coverage for 100% of Medicare Part B excess charges.

Plan F offers the most significant added benefit beyond Plans B, C, D and E: payment of 100% of what a doctor charges above the Medicare-approved amount. As shown in Table 6.6, Plan F is the most popular Medigap plan; 53% of those who have purchased a Medigap policy have chosen Plan F. Medigap Plan F is considered the "*Cadillac*" of Medigap Policies.

One area that Medigap Plan F does not cover is Hospice Care coinsurance or copayment. This can lead to a big financial strain for people in the position of facing hospice care. Hospice care costs add up quickly, and care may be required for a long period. Another benefit that other Medigap plans offer, that Plan F does not is coverage for preventive care not covered by Medicare, up to $120.00.

If the individual likes the coverage offered by Plan F but finds the higher premiums too much for their budget, many companies that offer Plan F also offer a high-deductible option of this plan for a much lower premium. These higher-deductible plans provide

coverage only when your client's out-of-pocket costs (excluding premiums) for covered services exceed a certain amount for the year of $2,870 in 2025. You must also pay a separate deductible ($250 per year) for foreign travel emergency services.

Note: Beginning January 1, 2020, Plan F was no longer available for sale to new Medicare enrollees. However, it will still be available to those individuals who have reached age 65 prior to January 1, 2020. This was due to the changes required under the Medicare Access and Chip Reauthorization Act (MACRA) of 2016 that supplemental plans covering the Part B deductible can no longer be purchased. The Act also eliminated High Deductible Plan F from the marketplace. If an individual has purchased one of these plans before 2020, they will be allowed to keep their coverage.

Medigap Plan G

Medigap Plan G provides the basic (core) benefits plus:

- Coverage for the Medicare Part A inpatient hospital deductible ($1,676 per benefit period in 2025).
- Coverage for the skilled nursing facility care coinsurance amount ($209.50 per day for 21 through 100 per benefit period in 2025).
- 100% coverage for medically necessary emergency care in a foreign country (up to plan limits); and
- Coverage for 100% of Medicare Part B excess charges.

Medicare Plan G remains a pillar of the 2010 Medicare Improvements for Patients and Providers Act (MIPPA). Medicare Plan G has all the coverage benefits found in Plan F, including the basic benefits required of all plans: Hospital Part A Deductible; Skilled Nursing; Coinsurance; Medicare Part B excess charges; and foreign travel expenses.

Only one benefit separating this plan from Medicare Plan F is the Medicare Part B deductible ($257 per calendar year in 2025).

Not Covered in Medigap Plan G Policies:

- *Hospice Care Coinsurance or Copayment:* Beneficiary may be required to pay up to $5 for each drug a hospice provides when they are getting hospice services in their home and 5% of the Medicare-approved amount for each day of inpatient respite care (up to certain limits).
- *Medicare Part B Deductible:* Beneficiary will need to cover the $257 yearly deductible (2025); and
- *Preventive Care not Covered by Medicare:* Beneficiary pays all costs.

Plan G premiums are competitively priced. Normally, the beneficiary will find a premium difference of about $13.00 per month between Plan G and Plan F. The $257 deductible amount needs to be satisfied before any portion of medical services; Medicare will pay for procedures or equipment. Although premiums are different by approximately $203, most Medicare beneficiaries will opt for Plan F over G as they prefer not to pay any

medical expense over and above their monthly premium. However, beginning January 1, 2020, Plan G will more than likely replace Plan F for those who are newly eligible for Medicare.

Plan G has a high deductible plan with a $2,870 deductible in 2025 before the plan will start coverage. You must also pay a separate deductible ($250 per year) for foreign travel emergency services.

Note: The popularity of Plan G may cause the insurers to increase their premiums after 2021.

Medigap Plan H

Medigap Plan H provides the basic (core) benefits plus:

- Coverage for the Medicare Part A inpatient hospital deductible ($1,676 per benefit period in 2025).
- Coverage for the skilled nursing facility care coinsurance amount ($209.50 per day for 21 through 100 per benefit period in 2025); and
- 100% coverage for medically necessary emergency care in a foreign country (up to plan limits).

Not Covered in Medigap Plan H Policies:

- *Hospice Care Coinsurance or Copayment:* Beneficiary may be required to pay up to $5 for each drug a hospice provides when they are getting hospice services in their home and 5% of the Medicare-approved amount for each day of inpatient respite care (up to certain limits);
- *Medicare Part B Deductible:* Beneficiary will need to cover the $257 yearly deductible in 2025.
- *At-home Recovery* (Medicare-approved home health care to provide treatment ordered by beneficiary's doctor for an illness or injury.) The beneficiary will pay 100% for services not covered by Medicare; and
- *Preventive Care not Covered by Medicare:* Beneficiary pays all costs.

Note: Effective June 1, 2010, Plan H was no longer sold. These plans now duplicate other plans because of the elimination of the at-home recovery and preventive benefits. If the beneficiary purchased a Medigap between July 31, 1992, and May 31, 2010, they could keep it, and their benefits will stay the same.

Medigap Plan I

Medigap Plan I provides the basic (core) benefits plus:

- Coverage for the Medicare Part A inpatient hospital deductible ($1,676 per benefit period in 2025).

- Coverage for the skilled nursing facility care coinsurance amount ($209.50 per day for 21 through 100 per benefit period in 2025).
- Medicare Part B Excess charges.
- Foreign Travel Emergency (up to plan limits); and
- At-Home Recovery (up to plan limits).

Not covered in Medigap Plan I Policies:

- *Medicare Part B Deductibles*–Beneficiary will need to cover the $257 yearly deductible in 2024: and
- *Additional Preventative Care Not Covered by Medicare.*

Note: Effective June 1, 2010, Plan I was no longer sold. These plans now duplicate other plans because of the elimination of the at-home recovery and preventive benefits. If the beneficiary purchased a Medigap between July 31, 1992, and May 31, 2010, they could keep it, and their benefits will stay the same.

Medigap Plan J

Medigap Plan J provides the basic (core) benefits plus:

- Coverage for the Medicare Part A inpatient hospital deductible ($1,676 per benefit period in 2025).
- Coverage for the skilled nursing facility care coinsurance amount ($209.50 per day for 21 through 100 per benefit period in 2025).
- Coverage for the Medicare Part B deductible ($257 per calendar year in 2025).
- 80% coverage for medically necessary emergency care in a foreign country.
- Coverage for 100% of Medicare Part B excess charges.
- At-home recovery; and
- Additional preventive care.

Not covered in Medigap Plan J Policies:

- *Hospice Care Coinsurance or Copayment*–Beneficiary may be required to pay up to $5 for each drug a hospice provides when they are getting hospice services in their home and 5% of the Medicare-approved amount for each day of inpatient respite care (up to certain limits).

Note: Effective June 1, 2010, Plan J is no longer being sold. These plans now duplicate other plans because of the elimination of the at-home recovery benefit and preventive benefits. If the beneficiary purchased a Medigap between July 31, 1992, and May 31, 2010, they could keep it, and their benefits will stay the same.

Medigap Plan K

Medigap K plan is structured slightly differently than the majority of the Medigap plans. Instead of providing the maximum amount of benefits, it focuses on reducing the individual's annual deductible. After beneficiaries meet their out-of-pocket yearly limit and their yearly Part B deductible ($257 in 2025), the policies are designed to pay 100% of covered services for the rest of the calendar year.

Medigap Plan K policies provide basic coverage in addition to other benefits. Basic coverage for Medigap Plan K policies includes:

- Medicare Part A Coinsurance and all costs after hospital benefits are exhausted.
- 50% of Medicare Part B Coinsurance or Copayment for other than preventative services.
- 50% Blood (first 3 pints). Medicare typically covers all costs associated with blood after the first 3 pints; and
- Medicare Preventive Care Part B Coinsurance.

In addition, Medigap Plan K policies provide the following additional benefits:

- 50% of Hospice Care Coinsurance or Copayment.
- 50% Skilled Nursing Facility Care Coinsurance; and
- 50% of Medicare Part A Deductible.

However, there is an annual limit on cost-sharing. Once the limit is met, Plan K starts paying for 100% of covered benefits, and the enrollee doesn't have to pay anything more. This is called an "out-of-pocket limit." The out-of-pocket limit for Plan K is $7,220 in 2025.

Not covered in Medigap Plan K Policies:

- Preventive Care not Covered by Medicare.
- At-home Recovery (Up to Plan Limits).
- Foreign Travel Emergency up to plan limits.
- Medicare Part B Excess Charges; and
- Medicare Part B Deductible.

Medigap Plan L

Medigap Plan L is designed to cover seventy-five (75) percent of basic and other common costs. Some benefits may be used often, while others may not be needed at all. Keep in mind that the beneficiary would have to pay out of pocket for these expenses without the Medigap coverage.

Medigap Plan L policies provide basic coverage in addition to other benefits:

- Medicare Part A Coinsurance and all costs after hospital benefits are exhausted.
- 75% of Medicare Part B Coinsurance or Copayment for other than preventative services.
- 75% of Blood (first 3 pints). Medicare typically covers all costs associated with blood after the first 3 pints; and
- Medicare Preventative Care Part B Coinsurance.

In addition, Medigap Plan L Policies provide the following additional benefits:

- 75% of Medicare Part A Deductible.
- 75% Hospice care coinsurance; and
- 75% Skilled nursing facility coinsurance.

Plan L has an out-of-pocket limit of $3,610 in 2025.

Note: Effective June 1, 2010, Plan L was no longer being sold. These plans now duplicate other plans because of the elimination of the at-home recovery and preventive benefits. If the beneficiary purchased a Medigap between July 31, 1992, and May 31, 2010, they could keep it, and their benefits will stay the same.

Not covered in Medigap Plan L Policies:

- *Medicare Part B Excess Charges:* For doctors and other providers who don't accept assignment, the beneficiary still must pay the difference between the Medicare-approved amount and either the provider's fee or the "limiting charge" (no more than 15% above the Medicare-approved amount) that applies for doctor's fees and many other Part B services.
- *At-home Recovery:* After the beneficiary leaves the hospital, they may still need to recuperate from surgery or other injuries. There may still be several health-related costs applied to the recovery effort. Doctors will often provide strict instructions for them to follow to get back to normal. Often these instructions will incur additional expenses. Medigap Plan L policies do not cover these expenses that Medicare doesn't cover; and
- *Foreign Travel Emergency:* Medicare does not cover healthcare coverage outside of the United States. Medigap Plan L does not provide any assistance in this area either. Medical emergencies in foreign countries requiring treatment or travel by the beneficiary must be paid in full out of pocket.

Medigap Plan M

Medigap Plan M policies were available as of June 1st. 2010. This plan has a lower premium due to the cost-sharing expenses that the individual must pay. Medigap Plan M is not offered in all states, nor is it offered by every insurance company.

Medigap Plan M would have out-of-pocket expenses of:

- Part A Deductible–50% of $1,676 in 2025; and
- Part B Deductible–$257 in 2025 annual per calendar year.

After that, Medigap Plan M covers everything Therefore, those who are healthy should find this plan a great option, and those seeking to return to Original Medicare and opt-out of their Medicare Advantage Plans.

Medigap Plan N

With a Plan N supplement, the beneficiary would have to pay a few small out-of-pocket expenses, and their Medigap plan would pick up the rest. Those expenses are:

- Medicare Part B Deductible–$257 per calendar year.
- Copay for Doctor's visits–Up to $20 per visit.
- Hospital ER Visit Copay–$50; and
- Excess charges.

Note: If the beneficiary's doctor does not accept Medicare assignment, they will pay a 15% excess charge. Plan N does not cover this like Plan F and Plan G would. However, it can be avoided by asking the provider upfront if they accept Medicare assignment.

Beyond these expenses, their plan will pick up the difference for any Medicare covered expense. Like any Medicare Supplement, there are no networks or a managed care system like a PPO, HMO, or an employer benefit health plan. The beneficiary's network is the entire United States. All Plan N policies are the same, no matter which insurance company the beneficiary may choose. Plan N is available in many states from various well-known insurance companies.

Plan N is the plan that budget-conscious beneficiaries choose. The lower premiums of Plan N make this plan a desirable offer for savvy seniors.

Medigap Premiums

Even though Medigap policies are standardized, premiums can vary from company to company. There are 3 methods companies use to set their premiums:

- *Issue age*–The issue age method bases the premium and future increases on the beneficiary's age when the policy was first issued. For instance, a company using this method can charge a higher premium to the beneficiary when they first buy the Medigap policy at 72 years old than to a beneficiary who first buys it at 65 years old.
- *Attained age*–The attained age method bases any premium increases on the beneficiary's current age at the time of the increase. In other words, a premium can increase based on their age as they get older in addition to other factors; or

- *Community age*–The community age method bases the premium, and any premium increases on the average age of everyone in the plan.

Some companies charge smokers a higher premium while other companies offer a variety of discounts. Very few companies charge everyone the same price, regardless of their age or marital status. Many companies charge a higher premium for a person with a disability who is younger than 65 years old than for someone 65 years or older for the same policy. Most companies increase the amount of their premiums each year due to increases in the cost of medical care. It is important to compare policies and premiums from different companies before buying a policy.

Issue Age

There are many ways to approach setting the premium for Medigap policies. All have their different positives and negatives. Some believe it matters when the beneficiary is accepted into the policy. In contrast, others believe that it doesn't matter at all, but it matters to them. One way to rate these policies for premiums is to use the issue-age rating, sometimes called the "entry age-rated" system.

This system believes that it matters what age the beneficiary is when they are admitted to the policy, affecting their premium. This type of rating system encourages people to get in early and start paying premiums to save money later. This makes the situation a little more pressing for them to get started and decide on a Medigap policy.

Policies that are issue-age rated can still be susceptible to inflation and other factors, but their age will not affect the premiums again. The amount of money they can save over a long time can be well worth getting into the Medigap act as soon as possible. Look for offers in the benefits of the beneficiary's area to supplement their Medicare policy and rest easy when medical conditions or treatments come their way.

The following states require Medicare Supplement companies to rate their policies using the issue-age method:

- Florida
- Arizona
- Idaho
- Georgia

Attained Age

The attractive part of an attained age-rated premium is that it comes with possibly the lowest premium of all to start. These premiums will be lower, to begin with, than any other supplemental plan, but watch out for the ill effects down the line. Just like the adjustable-rate mortgages that mirror the process, attained age premiums will come back to haunt the beneficiary.

Even though these premiums will start lower than anyone else, they will eventually be higher after years. This may seem attractive to save initially, but the scary idea is that they tend to have less and less income as the beneficiary gets older. They won't want their premiums to rise right when they happen to need money the most in their lives.

Thirty-eight states, AL, AK, CA, CO, DE, HI, IL, IN, IA, KS, KY, LA, MD, MI, MS, MO, MT, NE, NV, NH, NJ, NM, NC, ND, OH, OK, OR, PA, RI, SC, SD< Tn, TX, UT, VA, WV, WI, WY and the District of Columbia allow attained age ratings for premiums. Insurers in these states are permitted to use issue age or community rating for premiums but generally do not.

Community Age Rated

Medigap policies are no different than any other type of insurance whether it is private or not. It is designed to give the biggest number of people the most coverage possible to protect the public. There are multiple ways to consider and set prices to get the best premiums; one is called Community (or "no age-related") rating.

The biggest thing to remember about community ratings is that they are more fitting of their nickname of "no age-related" policies. These premiums for a policy are based on the amount it will take anybody in the area to obtain the insurance. In other words, regardless of the beneficiary's age or any other characteristic, the premiums will remain with this coverage because the decision was to charge everyone the same.

The downside of having one premium that applies to everyone and the beneficiary's age not being a factor is that the premium may be a little more erratic. Inflation is more of a factor with these policies because there are no changes if the beneficiary gets older, just inflation. So, the relief is that they know what their premium will be regardless of their age or financial situation.

Today, our society is dealing with the ill effects of adjustable-rate mortgages and the loss of homes they have created by falling apart. This same aspect can be seen in Medigap insurance if the beneficiary does not pay attention to the type of premium when they start their supplemental plan. The premium pricing plan of attained age rated will affect them in their pocket down the line more than it may seem.

The following are community age rated Medigap states:

- Arkansas
- Connecticut
- Massachusetts
- Maine
- Minnesota
- New York
- Vermont
- Washington

Medigap Premium Rates

Medigap premium rates have always varied dramatically for policies that offer identical coverage. To help understand the wide range of rates available and how one can save money, you can go to CMS at Find a Medigap policy that works for you at: www.medicare.gov/medigap-supplemental-insurance-plans/#/m/?year=2024&lang=en

Table 15.9 illustrates the broad ranges in the monthly premium rates for 10 standard plans Medigap plans for a 65-year-old male nonsmoker living in Tampa, Florida (zip code 34653).

Table 15.9
Medigap Premium Rates, Tampa Florida

Plan	Lowest Premium	Highest Premium
A	$135.00	$210.58
B	$178.00	$228.73
C	$185.66	$249.22
D	$196.18	$207.00
F	$186.27	$260.66
F HD	$46.00	$103.00
G	$170.40	$238.19
GHD	$46.00	$103.00
K	$60.65	$131.48
L	$123.61	$193.97
M	$183.60	$218.46
N	$129.00	$180.88

Source: www.medigap.com/medicare-by-state/florida/tamps/

Table 15.10 illustrates the broad ranges in the monthly premium rates for 10 standard plans Medigap plans for a 65-year-old male nonsmoker living in Miami, Florida (zip code 33128).

Table 15.10
Medigap Premium Rates, Miami Florida

Plan	Lowest Premium	Highest Premium
A	$181.00	$318.00
B	$238.00	$285.92
C	$270.75	$341,42
D	$267.84	$281.10
F	$271.66	$414.02

F HD	$61.00	$145.40
G	$219.78	$353.25
GHD	$61.00	$128.74
K	$86.99	$164.34
L	$171.26	$242.48
M	$260.60	$273.08
N	$169.99	$269.52

Source: www.medigap.com/medicare-by-state/florida/miami/

Choosing a Medigap Policy

Comparing two or more kinds of Medigap policies is often complicated; not only are the benefit designs of policies likely to be different (see Table 6.8), but so are their networks, premiums, and deductibles. However, it is important to remember, thanks to the U.S. Congress many years ago, standardized, and simplified Medigap policies were established. So today, there is a menu of 10 different plans to choose from, starting with Plan A, which is bare bones, all the way up through Plan N, which is top of the line. In nearly all states, nearly all the companies that sell a particular plan offer the same benefits, bells, and whistles as every other company that offers that plan. Three states provide their own Medigap policies: Massachusetts, Wisconsin, and Minnesota. Here are some steps to take to make policy comparisons and to choose the right Medigap policy to meet your client's needs:

- *Step 1: Estimate the Price of a Medigap Standard Plan F.* One way to simplify these comparisons is to estimate the price of a Medigap Standard Plan F, which is excellent commercially available insurance. Using this price as a benchmark, you can compare the prices and coverage of other alternatives. This price does not include prescription drug coverage, which can be determined later in the evaluation process if necessary. To be the greatest value, the Standard Plan F price should be specific to the beneficiary based on their age and the geographical area. Once they know this price, they can estimate the dollar value of the compromises required by the weaker plans (or the dollar value of the added benefits offered by employer plans). Also, the beneficiary may decide to buy the Standard Plan F, even though it is usually the most expensive option. Beneficiaries can use the Medigap premium comparisons published online by most state insurance departments to estimate the premiums for the Standard Plan F. Although premiums vary widely among insurers, online comparisons can help identify the lower range. Visit the Weiss policy price comparison link at: http://weissmedigap.com

  Reminder: Beginning in 2020, Plan F was no longer available to new Medicare enrollees. However, it will still be available to those individuals who have reached age 65 prior to January 1, 2020.

- *Step 2: Identify Their Selection Criteria.* If the beneficiary wants to consider less expensive options than a comprehensive Medigap policy, they should list two or three important criteria. According to one study, individuals' primary criterion is that a plan should have low premiums. If this is the first criterion that they use, it will often eliminate better plans. Instead, they should list criteria other than premiums. Then, once they have identified the plans that meet these other criteria, they can consider plan premiums in selecting coverage. Here is a list of some of the criteria that they may consider:
    - The ability to continue seeing their current physician.
    - Flexibility in choosing providers, particularly specialists, without going through a gatekeeper.
    - Low total costs (premiums, deductibles).
    - Protection from large losses; and
    - Benefits for services such as routine dental and vision care are not covered.
- *Step 3: Evaluate Coverage Options.* After the beneficiary has estimated what they would pay for a Medigap Standard Plan F and listed their selection criteria, they can evaluate plan options. If they have an employer plan, they should evaluate that plan first. One way of evaluating plans is to use side-by-side comparison.

Regulation of Medigap Policies

In first enacting federal minimum standards as part of the Social Security Act for Medigap products and issuers in 1980 and subsequent amendments to the law, Congress recognized the primary role of states in the regulation of private health insurance, including Medigap. Accordingly, the Social Security Act of 1965 stipulates that federal minimum standards for Medigap insurance must incorporate the NAIC Model Regulation to Implement the Medicare Supplement Insurance Minimum Standards Model Act (Model Regulation).

Role of the NAIC

A state's Medigap laws and regulations are deemed to meet the federal standards so long as its standards are equal to or more stringent than the federal statutory requirements and the NAIC Model Regulation standards. CMS recognizes any updated NAIC Model Regulation and incorporates its provisions into the federal requirements. States amend their laws and regulations to conform to the new Model Regulation to comply with federal law.

State Regulation

As described above, federal law establishes certain minimum requirements for Medigap coverage, but the states have primary enforcement jurisdiction over Medigap insurers and policies. State regulatory authority includes review and approval of premium rates, regulation of rating practices and enrollment rules, review, approval of policy forms, and all other aspects of insurance regulation. States may expand open enrollment and other

guaranteed rights to Medigap coverage beyond the requirements established by federal law. In fact, many have done so.

Medigap Enrollment Dates

Any individual may apply for a Medigap policy at any time, but companies selling Medigap plans can refuse to sell due to pre-existing conditions. Insurance companies may use health screening by asking questions about the individual's health before selling them a Medigap policy. However, there are certain times when by law, companies must sell a Medigap plan regardless of the beneficiary's health condition.

These times are called:

- Open Enrollment; and
- Guaranteed Issue.

These periods generally follow specific events that result in the loss of existing coverage.

Open Enrollment

As was discussed earlier in the chapter, in addition to standardizing the benefit package, OBRA-90 established a federal six-month "*open enrollment period"* for Medigap coverage beginning when a beneficiary is age 65 or older and enrolled in Medicare Part B. A beneficiary applying for a Medigap plan during this period may not be denied coverage and cannot be charged a higher premium because of poor health.

Even when a person buys a Medigap policy in this open enrollment period, the policy may still exclude coverage for "*pre-existing conditions*" during the first six months the policy is in force. Pre-existing conditions were either diagnosed or treated during the six-month period before the Medigap policy became effective.

If the beneficiary is enrolled in Medicare prior to age 65, Medigap insurers are required to offer coverage, regardless of medical history, for a six-month period when they reach age 65. Insurers are prohibited from discriminating against the price of policies based upon their health status.

Guaranteed Issue

Over the last two decades, federal laws (The Balanced Budget Act (BBA) of 1997, the Medicare, Medicaid, and SCHIP Balanced Budget Act (BBRA) of 1999, and the Medicare Modernization Act (MMA) of 2003) have expanded access to Medigap plans to include specific guaranteed issue (GI) opportunities upon the occurrence of certain qualifying events and subject to certain limitations. For example, a beneficiary may have a right to Medigap coverage on a GI basis if they terminate or lose coverage in a Medicare Advantage plan or lose coverage under an employer-sponsored plan or loss of

certain other coverage. Table 15.11 highlights the key differences between the federal Medigap open enrollment and GI rights.

Medicare Supplement Changes

Starting in 2020, there will be no more first-dollar coverage plans available to those considered Medicare eligible after 2020. First-dollar coverage plans are Medicare Supplement (Medigap) plans that leave the beneficiary with zero out-of-pocket costs.

The three Medicare Supplement Plans considered first-dollar coverage plans are:

- Plan C.
- Plan F; and
- High Deductible Plan F.

Table 15.11
Key Differences between Federal Open Enrollment and Guaranteed Issue Options

	Open Enrollment	Guarantee Issue
Eligibility	When the individual is at least 65 years old and is enrolled in Medicare Part B	Upon the occurrence of a qualifying event
Timing	6 months, beginning the first day of the month when an individual is both 65 or older and enrolled in Part B	63 days from a qualifying event
Pre-existing Condition Exclusion	Allowed. Maximum 6 months, reduced for prior creditable coverage	Prohibited
Choice of Policies	Any Medigap Plan available to new beneficiaries from any Medigap insurer in the state	Certain specified Medigap Plans from designated insurers (varies by qualifying event)

Reasons Why First-Dollar Coverage Plans are Being Discontinued

The Medicare Access and CHIP Reauthorization Act of 2015 eliminated all Medigap plans covering the Medicare Part B deductible. The reason for the change is that some members of Congress believe Medicare beneficiaries are over-using healthcare services. With no out-of-pocket costs, playing it safe was priceless.

By making everyone meet the Medicare Part B deductible, legislators hope to prevent beneficiaries from running to the doctor for every minor ailment. Critics argue that the deductible may keep people from getting the care they need. When people don't see a doctor, they can have more serious conditions down the road.

How Medicare Changes Will Impact Beneficiaries

These changes will only impact beneficiaries who are not considered "*Medicare-eligible*" until after 2020. If the beneficiary turned 65 prior to January 1, 2020, they could continue to enroll in these first-dollar coverage plans after they have been discontinued. They're only being discontinued to those beneficiaries who are not considered Medicare eligible until AFTER 2020.

Those currently enrolled in a first-dollar coverage plan will be grandfathered. They will not have to make any changes to their coverage unless they're simply comparing benefits or rates to see if there's a better plan for them.

Even if a beneficiary is Medicare-eligible before 2020 but doesn't enroll in Medicare Part B for one reason or another until after 2020, they can still enroll in a first-dollar coverage plan to supplement your Medicare benefits. Again, if the beneficiary is Medicare-eligible BEFORE 2020, they can still sign up for first-dollar coverage plans after they're discontinued.

For Those "Medicare-eligible" After 2021

For beneficiaries who are not eligible for Medicare until after 2020, they still have alternatives to keep their out-of-pocket costs low. The only difference between the alternative plans listed below and the first-dollar coverage plans is the Part B deductible, which is $257 as of 2025.

Alternatives to First-Dollar Coverage Plans

One alternative to Plan C is Plan N. Plan N is considered a cost-sharing plan. There is co-pay of up to $20 for doctor's visits and up to $50 in the emergency room. One good thing about Plan N is that if the beneficiary goes to urgent care vs. their primary care physician or emergency room, there is no co-pay.

Another alternative to Plan C is Plan D. Plan D offers the same protection as Plan C, except for covering the Part B deductible. If a beneficiary doesn't want the co-pays that come with Plan N, then Plan D may be the better option. Neither Plan D nor Plan N covers excess charges. If the beneficiary wants coverage for excess charges, they will want to go with Plan G.

An alternative to Plan F is Plan G. Aside from the Part B deductible, Plan G is the exact same plan as Plan F. This plan covers virtually all the beneficiaries' medical and hospitalization costs, including excess charges. Plan G is already a popular plan because it offers great coverage with a much lower premium than Plan F.

Plan G is a good bet if the beneficiary wants the fullest possible coverage. Once they meet the annual Part B deductible ($240 in 2024), they shouldn't have any further expenses for services covered by Medicare.

Plan N is a good choice if you're looking to save money on premiums, don't mind a small copay, and aren't concerned about excess charges. Excess charges aren't allowed in some states, and even where they're permitted, not all providers charge them. In fact, only 3% of providers charge excess charges.

Plan D and Plan G Will be Guaranteed Issue Plans

Another important fact, MACRA is making both Plan D and Plan G guaranteed issue plans for "*newly eligible*" Medicare beneficiaries who are not able to sign up for Plan C or Plan F.

Reminder: If the beneficiary is Medicare-eligible prior to 2020, they will not be given guaranteed issue for Plan D and Plan G. However, they will still be eligible for a guaranteed issue with Plan C and Plan F.

New High Deductible Plan G

Even though Medigap Plan F High Deductible is not really a first-dollar coverage plan, it's being discontinued since it's a plan that falls under Plan F. Good news is, there's a new high-deductible plan, high deductible Plan G. Beginning in 2021, any beneficiary can sign up for High-Deductible Plan G, regardless of if they're considered "Medicare-eligible" before or after 2020.

Table 15.12
2025 Medigap Plan Benefits

	A	B	C	D	F*	G	K**	L	M	N
Hospital Coinsurance. Co-insurance for days 61-90 ($419) and days 91-150 ($838) in hospital; Payment in full for 365 additional lifetime days.	■	■	■	■	■	■	■	■	■	■
Part B Coinsurance. Coinsurance for Part B services, such as doctor services, laboratory and X-ray services, durable medical	■	■	■	■	■	■	50%	75%	■	Except $20 for doctors' visits and $50 for emergency visits

	A	B	C	D	F*	G	K**	L	M	N
equipment, and hospital outpatient services.										
First three (3) pints of blood.	■	■	■	■	■	■	50%	75%	■	■
Hospital Deductible. Covers $1,676 in each benefit period.		■	■	■	■	■	50%	75%	50%	■
Skilled Nursing Facility (SNF) Daily Coinsurance. Covers $209.50/day for days 21-100 each benefit period.		■	■	■	■	■	50%	75%	■	■
Part B Annual Deductible. Covers $257			■		■					
Part B Excess Charges Benefit. 100% of Part B excess charges. (Under federal law, the excess limit is 15% more than Medicare's approved charge when provider does not take assignment; under NY State law, the excess limit is 5% for most services.					■	■				
Emergency Care Outside the	No	No	■	■	■	■			■	■

	A	B	C	D	F*	G	K**	L	M	N
U.S. 80% of emergency care costs during the first 60 days of each trip, after an annual deductible of $250, up to a maximum lifetime benefit of $50,000.										
100% of coinsurance for Part B-covered preventive care services after the Part B deductible has been paid ($257 in 2025).	■	■	■	■	■	■	■	■	■	■
Hospice Care. Coinsurance for respite care and other Part A-covered services.	■	■	■	■	■	■	50%	75%	■	■
High Deductible			$2,870		$2,870	$2,870				
Out of Pocket Limit (2025)							$7,220	$3,610		

*

Beginning January 1, 2020, Plans C and F were no longer be sold to newly eligible Medicare beneficiaries. Plan F and G offer a high-deductible option. In 2025 the beneficiary pays $2,870 deductible before coverage benefits begin. ** Out-of-pocket maximum for Plan K is $7,220 and for Plan L is $3,610 in 2025. After this amount the plans pay 100% for the Part A and Part B coinsurances. Starting June 1, 2010, Plans E, H, I, and J were no longer sold. These plans now duplicate other plans because of the elimination of the at home recover benefit and preventive benefits If the beneficiary purchased a Medigap between July 31, 1992, and May 31, 2010, they could keep it and their benefits will stay the same. The chart does not apply to Massachusetts, Minnesota, and Wisconsin. They have their own Medigap systems. Not all plans are available in all areas.

Further Reading

AHIP; The State of Medicare Supplement Coverage: Trends Enrollment and Demographics (released February 2024)
202402-AHIP_MedicareSuppCvg-v05.pdf (ahiporg-production.s3.amazonaws.com)

AHIP, The State of Medigap (March 2022):
https://www.ahip.org/documents/202202-AHIP_MedicareSuppCvg-02_v03.pdf

How to Compare Medigap Policies
https://www.medicare.gov/supplements-other-insurance/how-to-compare-medigap-policies

CMS, Find a Medigap policy that works for you (medicare.gov);
https://www.medicare.gov/medigap-supplemental-insurance-plans/#/m?lang=en&year=2021

Seniors' Satisfaction with their Medicare Supplemental Insurance Coverage released February 10, 2023
PowerPoint Presentation (ahiporg-production.s3.amazonaws.com)

CMS F, G, J Deductible Amounts, October 2024 Announcement
https://www.cms.gov/files/document/cy2025-medigap-high-deductible-options-fjg.pdf

Chapter 15
Review Questions

1. Which of the following statements about Medigap plans is FALSE?

( ) A. There is a six-month open enrollment
( ) B. Beneficiary must be enrolled in Part C
( ) C. There are 10 standardized plans
( ) D. Beneficiary must be age 65 or older

2. Which of the following Acts included a set of federal regulations that directed the National Association of Insurance Commissioners (NAIC) to establish a standardized set of Medigap plans?

( ) A. The Omnibus Budget Reconciliation Act (OBRA) of 1990
( ) B. Medicare Improvements for Patients and Providers Act (MIPPA) of 2008
( ) C. The Medicare Modernization Act (MMA) 2003
( ) D. Deficit Reduction Act of (DRA) 2005

3. For 2025, what is the out-of-pocket (OOP) limit for Medigap plan K?

( ) A. $240
( ) B. $1,632
( ) C. $7,220
( ) D. $505

4. For 2025, which of the following plans would be an alternative to Plan F for newly eligible Medicare beneficiaries?

( ) A. Plan B
( ) B. Plan G
( ) C. Plan C
( ) D. Plan A

5. The open enrollment period for Medigap policies is extended for how many months after one turn age 65?

( ) A. Seven months
( ) B. Three months
( ) C. Eight months
( ) D. Six months

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CHAPTER 16

OPTIONS FOR REFORMING MEDICARE

Overview

The Medicare health insurance program for seniors is the nation's biggest financial challenge. The changing demographics–10,000 Baby-Boomers turning 65 every day for the next 8 years–combined with the addition of a prescription drug benefit and rising health care costs generally–have created an unfunded liability of nearly $25 trillion over the lifetime of those now in the program as workers and retirees. That is the taxpayer's obligation, beyond what Medicare taxes will bring in, or seniors will pay in premiums for Medicare Part B –also called supplemental coverage–that helps pay for doctor visits and other expenses outside the hospital. I think you would agree that something must be done to reform Medicare to reduce the deficit and the debt. The question is: What should be done?

This chapter will examine a broad range of proposals for reforming Medicare. We will review both sides of the reform options, the arguments in favor (pro) and the arguments against (con), so that you can develop a better understanding of the choices involved and form an educated opinion on the best course for Medicare overall. Let's face reality: it will affect you in the future.

Learning Objectives

Upon completion of this chapter, you will be able to present the arguments for and against:

- Raising the Medicare eligibility age to 67.
- Raising Medicare premiums for higher income beneficiaries.
- Raising the payroll tax.
- Increasing supplemental plan costs and reducing coverage.
- Imposing cost-sharing for the first 20 days in a skilled nursing facility; and
- Requiring drug companies to give rebates or discounts to Medicare.

Background

During the Congressional talks about our national debt ceiling back in 2011, the nation's Medicare program may have been the single most-debated program. Certainly, it was a key cause of stonewalling by legislators on both sides of the Congressional aisle. Neither

party wants to be associated with anything which potentially hurts our Medicare beneficiaries.

The reality, they are, after all, one of the nation's largest voting blocks, and already radio and TV commercials resound about protecting the rights of senior citizens to continue their current Medicare program.

As former U.S. Comptroller, David Walker, chief U.S. Auditor, has stated,

> *"…these unfunded obligations need to be reformed sooner rather than later."*

We need to make decisions looking forward, not in the rearview mirror. Let's review some of those reform proposals.

Raise the Medicare Eligibility Age

Since Medicare's creation in 1965, the eligibility age has been 65 for people without disabilities. Some proposals would gradually raise Medicare's eligibility age from age 65 to 67. Like the increase in the age for Social Security full retirement age (FRA). So instead of receiving health coverage through Medicare, 65- and 66-year-olds would need to enroll in coverage through an employer plan (if they are still employed, or if the employer offers a plan as part of a retirement program); or a government program (such as Medicaid if their incomes and asset are below certain levels); or purchase their own coverage on the individual market through a health insurance exchange (additional costs in retirement for many people).

This option would raise the eligibility for Medicare like eligibility rules for Social Security, Full Retirement Age (FRA) until the eligibility age reached 67 for people born in 1960 (who will turn 67 in 2027). Thereafter, the eligibility age would remain at 67.

According to the Congressional Budget Office's estimates, this option would reduce federal spending by about $125 billion. Those estimates primarily reflect a reduction in federal spending on Medicare and a slight reduction in Social Security retirement benefits outlays. Those reductions would be partially offset by increasing federal spending on Medicaid and federal subsidies to purchase health insurance through the new insurance exchanges.

Argument in Favor

They argue that with more Americans living longer, and health spending on older people rising, we just can't afford Medicare at 65. Many believe that it makes sense to increase the eligibility age slowly over 10 or 15 years to at least 67–the Social Security normal (full) retirement age–and for the eligibility of both programs to rise gradually after that as Americans live longer. The projected cost savings for increasing the age to 67 over the next years are about 5 percent.

Argument Against

Those who oppose the increase in age claim that the savings on the federal budget deficit will be small, and total health care spending would rise. The reason, they claim, is that for every dollar the federal government would save from raising the Medicare eligibility age to 67, other costs would go up by $1.10. This would increase Medicaid spending, higher subsidy payments under the new health care law, and added spending by businesses and older people themselves. Furthermore, some predict raising the age of eligibility for Medicare would raise premiums for all other Medicare beneficiaries. The reason: 65–66-year-olds are less costly than older Medicare enrollees, and premiums are based on average costs.

Raise Medicare Premiums for Higher-Income Beneficiaries

Most Medicare beneficiaries pay a separate monthly premium for doctor visits (Part B) and prescription drug coverage (Part D) in Medicare. The premiums people pay for Part B and D cover about 25% of what Medicare spends on these services. Individuals with annual incomes of more than $103,000 and couples with annual income above $206,000 in 2024 pay higher premiums, up to three times the standard premium depending on income level. Currently, CMS has estimated that about 8% of Medicare beneficiaries pay excess premiums. Under several proposals, these higher-income beneficiaries would be required to pay as much as 15 percent more than they currently pay.

Argument in Favor

The best way to generate more premium revenue to help pay for Medicare Parts B and D is to raise premiums for higher-income beneficiaries. That would improve Medicare's finances by bringing in more premium revenue without imposing burdens on low and modest-income beneficiaries. Now some people say that is unfair. Because working Americans pay a flat Medicare payroll tax on their entire paycheck, they say that richer beneficiaries have already paid much more into Medicare. The payroll tax doesn't go to pay Medicare Parts B and D. It only goes toward the part of Medicare that pays for hospital services. Well-off beneficiaries enrolled in Part B, and Part D still receive large subsidies from other taxpayers, and that's unfair. Those beneficiaries with high incomes should pay the full cost of their taxpayer-subsidized Part B and Part D, not just a little more.

Argument Against

On the surface, it may seem reasonable to charge Medicare beneficiaries with higher income more for the same Part B and Part D coverage. However, many of these proposals will also push costs into more middle-class beneficiaries, particularly if the income level at which individuals are subject to the higher premium continues to be frozen (not indexed with inflation) or even reduced. Some propose to keep the income level at which beneficiaries must pay the higher premiums, already frozen for 10 years, at the same threshold for even longer. Over time, this means that more Medicare

beneficiaries will be required to pay higher premiums each year. Others have proposed that the thresholds be lowered. Under both proposals, middle-class beneficiaries would hit the income level that triggers higher premiums. It is estimated that 25 percent of all Medicare beneficiaries may have to pay Part B income-related premiums by 2035. The number of Medicare beneficiaries subject to Part D income-related premiums will similarly increase. This may lead many current beneficiaries to leave Medicare and purchase cheaper insurance protection or self-insure, making it more difficult for the federal government to manage risk within the Medicare program. Higher-income beneficiaries tend to be younger and healthier. They are needed in the program to balance (adverse selection) the costs of the sicker and less wealthy enrollees. If enough higher-income beneficiaries drop out of Part B and Part D, the premiums for Medicare Part B and Part D will need to increase for beneficiaries who remain in the program, making Medicare participation more expensive for almost everyone.

Generating New Revenue by Increasing the Payroll Tax Rate

The primary source of funding for Medicare hospital services (Part A) comes from the payroll tax. Under current law, workers and their employers each contribute 1.45 percent of their earnings for a total contribution of 2.90 percent. In addition, there is an additional 0.90 percent surtax on certain taxpayers with incomes above an applicable threshold. Medicare also offers coverage for physician services (Part B) and prescription drugs (Part D), but the payroll tax does not fund these services. It's estimated that beginning in 2036, Medicare will not have enough money to pay for all the expected hospital expenses. The proposal is to increase the current payroll tax rate from 2.9 percent to 3.9 percent (or to 1.95 percent each for workers and employers). This payroll tax increase would raise additional revenue for Medicare's inpatient hospital expenses. How much of an increase? For an individual earning about $50,000 a year in wages, this increase would amount to an extra $250 in Medicare payroll taxes per year.

Argument in Favor

Medicare Part A faces a modestly projected long-term deficit: that is, the available funds will not pay for all services, but the gap is small. Based on current projections, a 1 percentage point increase in the payroll tax would more than completely close that deficit. In fact, it would provide a modest cushion should current projections prove to be unduly optimistic. At the end of CY 2023, the HI Trust Fund had a balance of about $196.6 billion, total income was $415.3 billion and total expenses were $403.1 billion. The projected trust fund depletion date is 2036, 5 years later than estimated in 2023 Trustees Report. At that point, the fund's reserves will become depleted and continuing program income will be sufficient to pay 90 percent of total scheduled benefits.

HI income is projected to be higher than last year's estimates because both the number of covered workers and average wages are projected to be higher. With the retirement of the Baby-Boomer generation by 2030 it will keep spending above revenues. Boosting payroll taxes by just ½ a percentage point on workers and by the same amount on their

employers–a total of 1 percentage point that would increase the total payroll tax from 2.9 percent to 3.9 percent–would take care of the rest of the problem, with a bit to spare.

Argument Against

Addressing Medicare's long-term financial problems by raising payroll taxes on working Americans is not the answer. That will worsen the economy and our children and grandchildren and erode the political will to undertake much-needed reforms. Raising the Medicare payroll tax just to keep up with Medicare's hospital spending is not a good proposal for the following two reasons. First, raising the payroll tax means higher payroll taxes for each dollar earned by working Americans. That would slow economic growth–further harming our ability to afford health care in the future. Second, raising the payroll tax rate means that people who will pay most to reduce Medicare's burden on our children and grandchildren would be our children and especially our grandchildren. That's because higher payroll taxes today impose the biggest total burden on those who will have to work the longest before retiring. Worst still, the payroll tax is imposed on every dollar earned, so even those workers not earning enough to pay income taxes would still be hit. Third, raising taxes on someone in the future just takes the pressure off Congress to take sensible steps today so that we can ensure adequate and affordable health care now as well as in the future. There's no doubt about it; we need to reduce healthcare spending, but paying additional taxes is not the answer.

Increase Supplemental Plan Costs and Reduce Coverage

Even with Medicare coverage, seniors are often left with significant health care costs, so many people purchase supplemental private insurance coverage (such as Medigap plans) to reduce their out-of-pocket expenses. Studies have found that Medigap policyholders use about 25 percent more services than Medicare enrollees who have no supplemental coverage and about 10 percent more services than enrollees who have supplemental coverage from a former employer, which tends to reduce, but not eliminate, their cost-sharing liabilities. Those differences probably arise in part because of the incentive effects of cost-sharing and in part because of differences in health status and attitudes towards health care. Because Medicare enrollees with supplemental coverage are liable for only a portion of the costs of those additional services, it is taxpayers (through Medicare) and not supplemental insurers or the policyholders themselves who bear most of the resulting costs. Federal costs for Medicare could be reduced if Medigap plans were restructured. Policyholders faced some cost-sharing for Medicare services but still had a limit on their out-of-pocket costs.

This option presents three alternatives to reduce Medicare costs by modifying the cost-sharing that Medicare beneficiaries face. The first alternative would replace a single combined annual deductible of $550 covering all Part A and Part B services; a uniform coinsurance rate of 20 percent for amounts above that, including inpatient expenses); and an annual cap of $5,500 on each enrollee's total cost-sharing liabilities. If this option is elected, the CBO has estimated that federal outlays would be reduced by about $32 billion over the next few decades.

The second alternative would bar Medigap policies from paying any of the first $550 of an enrollee's cost-sharing liabilities and would limit coverage to 50 percent of the next $4,950 in Medicare cost-sharing. (The Medigap policy would cover all further cost-sharing, so enrollees in such policies would not pay more than about $3,025 in cost-sharing in that year).

The third alternative combines the restructuring parameters for the first two. Therefore, Medigap plans would be prohibited from covering any of the new $550 combined deductible–which would apply to both Part A and Part B of Medicare's fee-for-service program. Under this combined option, the level of beneficiary spending at which the Medigap policy's cap on out-of-pocket costs was reached would be equal to the level at which the Medicare program's cap was reached. Medigap policyholders would face a uniform coinsurance rate of 10 percent for all services for spending between the deductible and the cap on the out-of-pocket expenditures. Medicare beneficiaries without other types of supplemental coverage would face a uniform coinsurance rate of 20 percent for all services. If this option took effect and the various thresholds were indexed to growth in the per capita costs for the Medicare program in later years, federal outlays would be reduced by about $93 billion over the next few decades. Those savings do not equal the sum of the savings that would result from the first two alternatives because of the interactions between their effects.

Argument in Favor

Most Medicare beneficiaries have health insurance coverage in addition to Medicare. Some coverage comes from previous employers and some from Medicaid. Roughly one Medicare beneficiary in six buys private insurance themselves, called Medigap. The reason people want such coverage is straightforward: There are gaps in Medicare coverage. The HI deduction is large. Medicare does not cover all the cost of very long stays in a hospital or a nursing home. Beyond a certain point, Medicare stops paying altogether. The cost of lengthy illnesses can be financially crushing, despite Medicare benefits. People should be free to use their own money to protect themselves from financial risk. Still, the price for such coverage should accurately reflect the expected cost of the added protection, and, unfortunately, at present, it does not. The additional insurance that Medicare enrollees buy increases Medicare-covered services but cover only part of the cost of this increased service use. Taxpayers pay the rest. For example, a person may stay a bit longer in a skilled nursing home if supplemental insurance covers the daily copayment for stays longer than 20 days. Many supplemental insurance plans cover the copayment for the added days. The copayments do not cover the full costs of the additional days, and Medicare covers the rest. If some cuts in Medicare spending prove to be necessary to keep the Medicare program financially sound, limits on how Medigap insurance pays for services, in addition to those in current law, would have the side benefit of lowering Medigap premiums and might deter some people from using services that produce few benefits.

Argument Against

It would be unwise to increase the premium amounts for Medigap insurance or decrease the amount of coverage available to enrollees under these policies. There is no evidence that these reforms would deter Medicare beneficiaries from using unnecessary health care services. Further, Medigap reform proposals have an unfair effect on lower-income Medicare enrollees and those in poor health. About 20 percent of Medicare beneficiaries purchase some type of Medigap plan to help cover Medicare cost-sharing. Most of these policies (59 percent) provide "first dollar" coverage, which protects enrollees from having to incur any out-of-pocket costs for Medicare services in exchange for a monthly premium. Supplemental insurance programs like Medigap make health care expenses more predictable and easier to manage on a fixed income. If the concern is over-utilization and unnecessary use of health care services, there are less burdensome and more direct ways to address the problem. Many beneficiaries are not able to determine whether a service is necessary or not, and they should not be placed in a position of having to decide based on their ability to pay. In addition, there is also an equity issue inherent in proposals that target Medigap without reforming other forms of supplemental coverage. Beneficiaries who purchase Medigap coverage are less likely to have access to other forms of supplemental coverage, such as employer-sponsored insurance or Medicaid. Most Medigap reform proposals do not include similar premium and cost-sharing restrictions on these other types of supplemental coverage. This would place Medigap enrollees at an unfair financial disadvantage when affording supplemental insurance or covering Medicare out-of-pocket costs.

Impose Cost-sharing for the First 20 days of a Stay in an SNF

For beneficiaries who have been hospitalized and need continuing skilled nursing care (SNF) or rehabilitative services daily, Medicare currently covers up to 100 days of care in a skilled nursing facility (SNF) for each episode of care. There is no deductible for SNF care and no copayment for the first 20 days of each stay. A daily co-payment is required for days 21 through 100; that copayment is set at 12.5 percent of the hospital inpatient deductible and is $209.50 ($1,676 x 12.5%) in 2025. A substantial share of Medicare SNF stays are shorter than 20 days and therefore do not require any copayments.

The maximum additional liability for each SNF stay would thus equal the inpatient deductible, which is $1,676 in 2025. Imposing that copayment would reduce federal outlays by about $21 billion over the next two decades.

Argument in Favor

The argument in favor of this option would discourage using Medicare-covered SNF services that may have limited value. For those beneficiaries who would incur higher out-of-pocket costs under this option, the absence of cost-sharing under current law for the first 20 days of SNF care encourages additional use of those services, some of which may not be clinically necessary.

Argument Against

One argument against this option is that the added copayment could lead some beneficiaries to forgo services that would help avoid further complications from surgery or improve their health in other ways. Some beneficiaries would probably choose instead to receive similar services through other benefits in Medicare, such as the home health care benefit, that currently have no cost-sharing and would not have any cost-sharing under this option. In addition, expenditures for states would rise due to the increase in copayments that Medicaid would cover.

Require Drug Companies to Give Rebates or Discounts to Medicare

Under current law, drug manufacturers are required to give rebates or discounts to the Medicaid program for prescription drugs purchased by Medicaid beneficiaries. However, the optional prescription drug coverage, Medicare Part D, does not require similar manufacturer rebates or discounts. This proposal would require manufacturers to provide Medicare with the same rebates or discounts as those that Medicaid receives for drugs purchased by certain low-income Part D enrollees.

The Medicare Modernization Act (MMA), which took effect in 2006, provided an unintentional multibillion-dollar windfall for drug companies at the expense of the American taxpayer.

Here is how it happened. Before 2006, between 15 and 20 percent of Medicare enrollees received drug coverage under Medicaid (a different government program) because they are poor or disabled. Under federal rules, drug companies are required to give Medicaid sizable discounts below the price charged to others. (The Veterans Administration demands–and gets–similar discounts.) The MMA transferred those Medicare enrollees also covered by Medicaid–the so-called "dual eligible"–to the new drug benefit for Medicare enrollees, Part D.

Part D is administered by private companies rather than the government. These companies, in many cases, lacked the power to negotiate discounts as large as Medicaid received and, for some drugs, could not negotiate much of a discount at all. As a result, the price of drugs for Medicare enrollees is higher than that under Medicaid and other government programs.

The cost is high. dual eligible are much heavier users of drugs than the average Medicare enrollee, particularly heavy users of some expensive drugs. As a result, they account for well over half of all spending under Medicare Part D. If drug companies were required to give the same discounts for drugs for dual eligible and other low-income beneficiaries as they now provide for Medicaid enrollees, Medicare spending would be cut by $112 billion over the next decade.

Note: Democrats add drug cost curbs to the Social Policy plan to allow for the first time to negotiate prices for medications covered by Medicare. Stay Tuned

Argument in Favor

These savings would spare the nation the need to raise taxes or cut other spending by similar amounts. That is why many groups that have proposed ways to cut the overall deficit and Medicare spending have endorsed this change.

Nothing comes for free, however. Drug companies indisputably use the expectation of profits to guide research to find new drugs. Experts believe that the impact of restoring the discounts on drug sales for dual eligible may somewhat discourage research. Not all new drugs are better than old ones. Drug companies are now spending more on marketing than research. This is a good place to begin if spending must be cut somewhere–and it does.

Argument Against

Some people think that requiring drug companies to reduce the prices they charge Medicare for low-income older people with Part D drug coverage would reduce Part D costs and be a good idea. It would not be–prices would just go up for other Americans, and there would be less research on cures for diseases like Alzheimer's.

Another reason it is a bad idea is that making drug firms cut their prices in one place just means they will tend to raise them somewhere else, just as squeezing one end of a balloon causes it to expand somewhere else. That's why it turns out that when your bank is told to end a fee on one service, it just raises the fee on another service. So, requiring a reduction–known as a "rebate"–on the cost of drugs for some or all older people in Medicare Part D just means someone else will pay more, such as working Americans who have to fill prescriptions for themselves or their children.

Let's say the drug firms that were forced to give rebates in Medicare were somehow not able to recover the lost revenue from higher charges on other Americans. That would mean the total revenue they obtained from those drugs widely used by older people would fall. That might seem to be no problem for Medicare beneficiaries–just a problem for the companies and their investors, but there's more to it. Knowing they would have to give the Medicare program rebates on future new drugs would make it less attractive for these firms to make the heavy and risky investments needed to find better drugs for diseases primarily afflicting older people, such as Alzheimer's. That would be bad news for both todays and tomorrow's older Americans. The bigger the forced rebate, the greater the disincentive to invest in breakthrough drugs aimed at older people.

Medicare Outlook

According to the Center on Budget and Policy Priorities, claims by some policymakers that the Medicare program is nearing "bankruptcy" are misleading. In fact, based on their

report, *"Medicare Is Not Bankrupt,"* they agree that Medicare faces major financing challenges. However, the program is not on the verge of bankruptcy or ceasing to operate. Such charges represent misunderstanding (or misrepresentation) of Medicare finances.

According to the report, Medicare financing challenges would be significantly greater without the health reform law (the Affordable Care Act, or ACA), which substantially improved the program's financial outlook.

However, I think we would all agree that some reforms mentioned above should be enacted to protect our senior's health care for the future.

What Are the Implications of Repealing the Affordable Care Act for Medicare Spending and Beneficiaries?

The 2010 Affordable Care Act (ACA) included many provisions affecting the Medicare program and the 63 million seniors and people with disabilities who rely on Medicare for their health insurance coverage. Such provisions include reductions in the growth in Medicare payments to hospitals and other health care providers and Medicare Advantage plans, benefit improvements, payment and delivery system reforms, higher premiums for higher-income beneficiaries, and new revenues.

Below we will explore the implications for Medicare and beneficiaries of repealing Medicare provisions in the ACA. The Congressional Budget Office (CBO) has estimated that full repeal of the ACA would increase Medicare spending by $802 billion from 2016 to 2025. Full repeal would increase spending primarily by restoring higher payments to health care providers and Medicare Advantage plans.

The increase in Medicare spending would likely lead to higher Medicare premiums, deductibles, and cost-sharing for beneficiaries and accelerate the insolvency of the Medicare Part A trust fund. Policymakers will confront decisions about the Medicare provisions in the ACA in their efforts to repeal and replace the law.

What are the key Medicare provisions in the ACA, and how would repeal affect Medicare spending and beneficiaries?

The following highlights several of the key Medicare provisions in the ACA, and it assesses how the repeal of these provisions could affect Medicare spending and beneficiaries.

Payments to Health Care Providers

The ACA reduced updates in Medicare payment levels to hospitals, skilled nursing facilities, hospice and home health providers, and other health care providers. The ACA

also reduced the Medicare Disproportionate Share Hospital (DSH) payments that help compensate hospitals for providing care to low-income and uninsured patients, expecting that hospitals would have fewer uninsured patients due to ACA's coverage expansions.

Repealing the ACA's sustained reductions in provider payments would be expected to:

- Increase Part A and Part B spending. CBO has estimated that roughly $350 billion of the total $802 billion in higher Medicare spending over 10 years could result from repealing ACA provisions that changed provider payment rates in traditional Medicare. Repealing these provisions would increase payments to providers in traditional Medicare. Additionally, some hospitals would receive higher DSH payments if these payments were restored to their pre-ACA levels; and
- Increase the Part A deductible and copayments and the Part B premium and deductible paid by beneficiaries. The Part A deductible and copayments would be expected to increase due to an increase in Part A spending that would likely occur if payment reductions were repealed. This is because the Part A deductible for inpatient hospital stays is indexed to updates in hospital payments. The copayment amounts for inpatient hospital and skilled nursing facility stays are calculated as a percentage of the Part A deductible. Similarly, the Part B premium and deductible would be expected to increase if payments to Part B service providers are restored. This is because Part B premiums are set to cover 25 percent of Part B spending, and the Part B deductible is indexed to rise at the same rate as the Part B premium.

Payments to Medicare Advantage Plans

Prior to the ACA, federal payments to Medicare Advantage plans per enrollee were 14 percent higher than the cost of covering similar beneficiaries under the traditional Medicare program, according to the Medicare Payment Advisory Commission (MedPAC). The ACA reduced payments to MA plans over six years, bringing these payments closer to the average costs of care under the traditional Medicare program. In 2023, plan payments will remain higher than FFS spending levels. Total Medicare payments to MA plans (including rebates that finance extra benefits) average an estimated 109 percent of projected FFS spending up 1 percentage point from 2022.

Repealing the ACA's Medicare Advantage payment changes would be expected to:

- Increase total Medicare spending because of increasing payments to Medicare Advantage plans relative to spending under traditional Medicare. CBO has estimated that repealing the Medicare Advantage-related provisions in the ACA would increase Medicare spending by roughly $350 billion (out of the $802 billion total increase) over 10 years.
- Increase Part B premium and deductible paid by beneficiaries. The Part B premium and deductible would likely increase if the payment reductions for Medicare Advantage plans are repealed because the Part B premium is set to cover 25 percent of Part B spending, and the Part B deductible is indexed to rise at the same rate as the Part B premium; and

- Improve benefits and lower out-of-pocket costs for beneficiaries enrolled in Medicare Advantage plans. Payments that Medicare Advantage plans receive in excess of their costs to provide Part A and Part B benefits are required to be used to provide benefits not covered by traditional Medicare, to reduce cost-sharing, premiums, or limits on out-of-pocket spending, or both. Thus, if the ACA's reductions in Medicare Advantage plan payments were repealed, plans could provide extra benefits to Medicare Advantage enrollees and/or reduce enrollees' costs.

Medicare Benefit Improvements

The ACA included provisions to improve Medicare benefits by providing free coverage for some preventive benefits, such as screenings for breast and colorectal cancer, cardiovascular disease, diabetes, and closing (or "donut hole") in the Part D drug benefit by 2020. These benefit improvements increased Medicare Part B and Part D spending.

Repealing the ACA's Medicare benefit improvements would be expected to:

- Reduce Medicare Part B spending for preventive services and reduce Part D spending on costs in the coverage gap.
- Increase beneficiary cost-sharing for Part B preventive benefits.
- Increase beneficiary cost-sharing by Part D enrollees who have drug spending high enough to reach the coverage gap. According to MedPac, in 2019, roughly 9.0 percent of Part D enrollees had spent high enough to reach the catastrophic phase of the benefit (high-cost enrollees), up from 8.3 percent in 2018. In 2019, the number of beneficiaries reaching the catastrophic phase grew 12 percent to 4.3 million. The growth was driven by the largest ever increase in the number of beneficiaries without the LIS reaching the catastrophic phase, which rose by 33 percent; and
- Reduce Part D premiums, on average, since Part D premiums are set to cover 25.5 percent of program costs and reinstating the Part D coverage gap would lower Part D spending.

Revenues to the Medicare Trust Funds

The ACA established new sources of revenue dedicated to the Medicare program, including a 0.9 percentage point increase in the Medicare Part A payroll tax on earnings of higher-income workers (incomes more than $200,000/individual and $250,000/couple), and a fee on the manufacturers and importers of branded drugs, which has generated additional revenue for the Part B trust fund, including $3 billion in 2015 alone. The Tax Policy Center Briefing Book projects these taxes to generate $35 billion in the year 2022.

Repealing the ACA's Medicare revenue provisions would be expected to:

- Reduce revenues to Medicare's Part A and Part B trust funds; and
- Reduce Part A payroll taxes for Medicare beneficiaries (and other taxpayers) with earnings greater than $200,000/individual or $250,000/couple.

Medicare Part B and Part D Premiums for Higher-Income Beneficiaries

The ACA froze the income thresholds for the Part B income-related premium beginning through 2019, which subjected a larger share of Medicare beneficiaries to the higher Part B income-related premium over time. The law also added a new surcharge to Part D premiums for higher-income enrollees, using the same income thresholds as Part B premiums.

Repealing the ACA's income-related premium provisions would be expected to:

- Reduce the number of higher-income Part B enrollees paying income-related premiums; and
- Reduce Part D premiums for beneficiaries with incomes above $106,000/individual and $212,000/couple in 2025.

Payment and Delivery System Reforms and New Quality Incentives

Through a new Center for Medicare & Medicaid Innovation (CMMI, or Innovation Center) within the Centers for Medicare & Medicaid Services (CMS), the ACA directed CMS to evaluate and implement new approaches for Medicare to pay doctors, hospitals, and other providers to bring about changes in how providers organize and deliver care. The ACA authorized the Secretary of Health and Human Services to expand CMMI models into Medicare if evaluation results showed that they either reduced spending without harming the quality of care or improved the quality of care without increasing spending. CMMI received an initial appropriation of $10 billion in 2010 for payment and delivery system reform model development and evaluation. The ACA called for additional appropriations of $10 billion each decade beginning in 2020.

The ACA also created incentives for hospitals to reduce preventable readmissions and hospital-acquired conditions and established new accountable care organizations (ACO) programs. Research has shown declines in Medicare patient readmissions since the Hospital Readmission Penalty Program provisions were introduced.

Repealing these ACA's payment and delivery system reform provisions would be expected to:

- Increase Medicare spending due to the elimination of CMMI and other quality incentive programs. On net, CBO has estimated that CMMI's operations will generate savings of $34 billion over the 2017-2026 period, with gross savings of $45 billion over this period. These savings are attributed to the expansion of successful payment and delivery system reform models into Medicare. In addition to eliminating the savings generated by CMMI, Medicare spending could also increase if the incentives to reduce preventable readmissions and hospital-acquired conditions are included in proposals to repeal and replace the ACA.

Independent Payment Advisory Board

The ACA authorized a new Independent Payment Advisory Board (IPAB). This 15-member board is required to recommend Medicare spending reductions to Congress if projected spending growth exceeds specified target levels, with the recommendations taking effect according to a process outlined in the ACA. To date, no members have been appointed to the Board. Many policymakers have expressed opposition to IPAB, and there have been several legislative attempts to eliminate it.

Repealing IPAB would be expected to:

- Increase Medicare spending over time, in the absence of the Board's cost-reducing actions. CBO projects Medicare savings of $8 billion because of the IPAB process between 2019 and 2026.

How would ACA repeal affect the solvency of the Medicare Hospital Insurance Trust Fund?

Fully repealing the ACA would accelerate the projected insolvency of the Medicare Hospital Insurance (HI) Trust Fund, out of which Part A benefits are paid. This would result from higher spending for Part A services due to higher payments to Part A service providers (such as hospitals) and Medicare Advantage plans for services provided under Part A, along with reduced revenues, if the additional 0.9 percent payroll tax on high earners is repealed. As a result, Medicare would not fulfill its obligation to pay for all Part A-covered benefits within a shorter period if the ACA is repealed than if the law is retained.

Prior to the enactment of the ACA in 2010, the Medicare Trustees projected that the Part A trust fund would not have sufficient funds to pay all Part A benefits beginning in 2017. Following the enactment of the law, the insolvency date was extended. The current insolvency date is projected to be 2036, according to the 2024 Medicare Trustees Report. Repealing the ACA is expected to push up the insolvency date.

Discussion

The Medicare provisions of the ACA have played an important role in strengthening Medicare's financial status for the future while offsetting some of the cost of the coverage expansions of the ACA and providing some additional benefits to people with Medicare. Savings were achieved in part by reducing payments to providers, such as hospitals and skilled nursing facilities. Medicare provider payment changes in the ACA were adopted in conjunction with the ACA's insurance coverage expansions, expecting that additional revenue from newly insured Americans would offset lower revenue from Medicare payments. In addition, Medicare savings were achieved through lower payments to Medicare Advantage plans.

Most Americans have expressed support for some of the ACA provisions that affect Medicare, including the elimination of out-of-pocket costs for many preventive services, closing the Part D coverage gap, and the higher Medicare payroll tax for higher-income workers. Some industry stakeholders have expressed concern about the implications of retaining the ACA's savings provisions yet repealing the ACA's coverage expansions.

Aside from uncertainty about whether any of the ACA's Medicare provisions will be retained, questions have arisen as to what changes policymakers could advance through the legislative process known as "reconciliation." Policymakers consider repealing the ACA as part of budget reconciliation legislation, requiring only a simple Senate majority to pass. Senate rules (the so-called "Byrd Rule") limit the scope of reconciliation legislation to provisions with budgetary effects, including spending and revenues. According to CBO, most of the Medicare provisions in the ACA have budgetary effects, so they would likely be considered in order in the context of a reconciliation bill.

As a result of the Medicare provisions included in the ACA, Medicare spending per beneficiary has grown more slowly than private health insurance spending; premiums and cost-sharing for many Medicare-covered services are lower than they would have been without the ACA; new payment and delivery system reforms are being developed and evaluated, and the Medicare Part A trust fund has gained additional years of solvency. Full repeal of the Medicare provisions in the ACA would increase payments to hospitals and other health care providers and Medicare Advantage plans, likely leading to higher premiums, deductibles, and cost-sharing for Medicare-covered services paid by people with Medicare. Full repeal would also reduce premiums for higher-income beneficiaries and reduce payroll tax contributions from beneficiaries (and other taxpayers) with high earnings. Repealing the ACA would have uncertain effects on evolving payment and delivery system reforms. Partial repeal of the law could also have implications for Medicare spending, the Part A trust fund solvency date, and beneficiaries' costs. Policymakers who seek to repeal the ACA may need to address the implications for Medicare, beneficiaries, and other stakeholders.

Further Reading

MedPac, Report To The Congress, Medicare Payment Policy, March 15, 2024
March 2024 Report to the Congress: Medicare Payment Policy – MedPAC

MedPac, Health Care Spending and the Medicare Program, July 16, 2024
July 2024 Data Book: Health Care Spending and the Medicare Program – MedPAC

Chapter 16
Review Questions

1. What is the usual age of eligibility for Medicare benefits?

( ) A. Age 65
( ) B. Age 62
( ) C. Age 66
( ) D. Age 67

2. One option to save Medicare finances would be to increase the age of eligibility for people born after 1960 to what age?

( ) A. 66
( ) B. 67
( ) C. 70
( ) D. 72

3. Under current law, workers, and their employers each contribute what percent of earnings for to Medicare? percent of earnings

( ) A. 2.90%
( ) B. 0.9%
( ) C. 1.45%
( ) D. 3.5%

4. Part D is administered by_____.

( ) A. Social Security Administration
( ) B. MedPac
( ) C. Private companies
( ) D. The government

5. The daily copayment for SNF for days 21 through 100 is set at what percent of the hospital inpatient deductible?

( ) A. 20.0%
( ) B. 25.0%
( ) C. 45.0%
( ) D. 12.5%

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SECTION THREE

MEDICAID

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CHAPTER 17

INTRODUCTION TO MEDICAID

Overview

Medicaid provides health and long-term care coverage for low-income families who lack access to other affordable coverage options; for individuals with disabilities for whom private coverage is often not available or inadequate; and for Medicare beneficiaries who need assistance with cost-sharing or services not covered by Medicare. All states have elected to participate in Medicaid as a means of financing the costs of health care and long-term care services for their low-income residents.

This chapter will examine the basic elements of Medicaid, focusing on the federal rules governing who is eligible, what services are covered, how the program is financed, and how beneficiaries share in the cost of care. The end of the chapter will examine changes to the Medicaid program under ACA and Medicaid expansion program and outline the future outlook of Medicaid.

Learning Objectives

Upon completion of this chapter, you will be able to:

- Review the background of Medicaid.
- Determine eligibility for Medicaid.
- Distinguish between Categorically Needy vs. Medically Needy.
- Apply income and resource limits.
- Outline the various medical services and costs provided by Medicaid.
- Present the new rules under the Deficit Reduction Act of 2005.
- Identify the changes to the Medicaid program under the ACA and Medicaid expansion program; and
- Describe the outlook of Medicaid.

Background

The Medicaid program was enacted in the same legislation that created the Medicare program–the Social Security Amendments of 1965 (P.L. 89-97). Prior to the passage of this law, health care services for the indigent were provided mainly through a patchwork of programs sponsored by state and local governments, charities, and community hospitals.

Before 1965, federal assistance to the states for health care was provided through two grant programs. The first program was established in 1950 and provided federal matching funds for state payments to medical providers on behalf of individuals receiving public assistance. In 1960, the Kerr-Mills Act created a new program called "*Medical Assistance for the Aged*." This means-tested grant program provided federal funds to states that chose to cover the "*medically needy*" aged who were defined as elderly individuals with incomes above levels needed to qualify for public assistance but in need of assistance for medical expenses.

In 1965, Congress adopted a combination of approaches to improve access to health care for the elderly. The Social Security Amendments of 1965 created a hospital insurance (HI) program to cover nearly all the elderly (Medicare Part A), a voluntary supplementary medical insurance program (Medicare Part B), and an expansion of the Kerr-Mills program to help elderly individuals with out-of-pocket expenses such as premiums, copayments, deductibles, and costs for uncovered services. At the same time, Congress decided to extend the Kerr-Mills program–now the Medicaid program–to cover other populations, including families with children, the blind, and the disabled.

In general, Medicaid provides three types of critical health protection:

- Health insurance for low-income families with children and people with disabilities.
- Long-term care for older Americans and individuals with disabilities; and
- Supplemental coverage for low-income Medicare beneficiaries for services not covered by Medicare (e.g., outpatient prescription drugs) and Medicare premiums, deductibles, and cost-sharing.

Since its inception, the Medicaid program has expanded in several different directions. In 1997, federal laws changed virtually every aspect of the program, affecting eligibility, benefits, beneficiary cost-sharing, and fraud and abuse protections. Most recently, with the enactment of the Patient Protection and Affordable Care Act (ACA: P.L. 111-148, as amended).

State Participation Requirements

As mentioned above, Medicaid is a joint federal and state program. State participation in Medicaid is voluntary, though all states, the District of Columbia, and the territories choose to participate. So, each state establishes its own eligibility standards, benefits package, payment rates, and program administration under broad federal guidelines.

To participate in Medicaid, states must provide coverage for a core set of benefits ("*traditional benefits*"). Still, states can also receive federal matching funds for coverage of "*optional benefits*." States have significant flexibility to expand beyond program minimums for benefits and coverage, determine how care is delivered, and determine what and how providers are paid.

For example, states can implement reasonable limits on the number of prescriptions a beneficiary can have refilled in a month before a more stringent review is applied or set reasonable limits on the number of physician visits in a year. Within federal guidelines, states may also decide whether to charge nominal cost-sharing to beneficiaries. However, federal Medicaid rules limit the amount of cost-sharing that can be charged to Medicaid beneficiaries, with particularly strong restrictions on the application of cost-sharing for pregnant women, children, and adults with income below the poverty level.

As a result of this flexibility, there is significant variation in Medicaid programs across states. Beyond these policy choices, other factors such as a state's ability to raise revenue, the need for public services, the health care markets in which Medicaid operate, and the policy process all lead to variation in Medicaid programs and spending. States are responsible for administering their Medicaid programs.

Medicaid Financing

State and federal dollars finance Medicaid. The federal share varies based on a formula in federal law that relies on states' average per capita income compared to the national average; states with lower incomes have a higher federal medical assistance percentage (FMAP).

The federal and state governments share the cost of Medicaid. The federal government reimburses states for a portion (the "*federal share*") of a state's Medicaid program costs.

Because Medicaid is an open-ended entitlement, there is no upper limit or cap on the amount of federal funds a state may receive. Medicaid costs in a given state and year are primarily determined by the expansiveness of eligibility rules and beneficiary participation, the breadth of benefits offered, the generosity of provider reimbursement rates, and other supplemental payments.

The state-specific federal share for benefit costs is determined by a formula set in law that establishes higher federal shares for states with per capita personal income levels lower than the national average (and vice versa for states with per capita personal income levels that are higher than the national average).

The federal share called the *federal medical assistance percentage* (FMAP) is at least 50 percent. It can be as high as 83 percent (statutory maximum). For FY 2024-2025, the FMAP varies across states from a floor of 50.00 percent (a multiplier effect of $1.00 in federal funding per $1 of state spending on Medicaid) to a high of 76.90 percent ($3.33 in federal funding per $1 in state spending). For FY 2024-2025, regular FMAP rates range from 50.00% (10 states) to 76.90% (Mississippi).

You can view specific state FMAP for Medicaid and Multiplier at: Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier | KFF

The federal match for administrative expenditures does not vary by state and is generally 50 percent, but certain administrative functions have a higher federal matching rate. Functions with a 75 percent federal match include, for example, survey and certification of nursing facilities, operation of a state Medicaid fraud control unit (MFCU), and operation of an approved Medicaid management information system (MMIS) for claims and information processing. Overall, administrative costs represent about 5 percent of total Medicaid spending each year.

The ACA included provisions that changed certain payments to states under Medicaid. Most notably, the ACA provides initial FMAP rates of up to 100% for certain "newly eligible" individuals. Also, under the ACA, "expansion states" receive an enhanced FMAP rate for certain individuals. In addition, ACA provides increased FMAP rates for certain disaster-affected states, primary care payment rate increases, specified preventive services, immunizations, smoking cessation services for pregnant women, specified home and community-based services, health home services for certain people with chronic conditions, home, and community-based attendant services and supports, and state balancing incentive payments.

Medicaid Enrollment and Total Spending

As of March 2025, 78,577,962 people were enrolled in Medicaid and CHIP in the 50 states and the District of Columbia, according to the monthly Medicaid and Chip Eligibility Operations and Enrollment Snapshot.

- 71,258,215 people enrolled in Medicaid; and
- 7,319,747 people were enrolled in CHIP.

According to the Kaiser Family Foundation (KKF), for a three-year period following the onset of the COVID-19 pandemic, states provided continuous Medicaid enrollment in exchange for an increase in the federal share of Medicaid spending (known as the Federal Medical Assistance Percentage (or "FMAP"). This policy resulted in the largest ever number of enrollees in Medicaid, which, along with enhanced subsidies in the Affordable Care Act (ACA) Marketplaces, contributed to the lowest ever uninsured rate. The 2023 Consolidated Appropriations Act (CAA) ended the continuous enrollment provision on March 31, 2023, requiring states to begin the process of "unwinding", and millions of individuals have been disenrolled from Medicaid since the unwinding began. Most states began unwinding related disenrollments in late state fiscal year (FY) 2023 (which ended June 30 in most states) and completed disenrollments in late FY 2024, though state unwinding timelines vary. The CAA also phased down the enhanced federal matching funds through the end of 2023 (partway through FY 2024 for most states).

Heading into FY 2025, states are expected to wrap up unwinding-related eligibility redeterminations; however, uncertainty remains regarding post-unwinding Medicaid spending and enrollment trends and what the new "normal" will look like. Adding to this uncertainty are the loss of pandemic-related enhanced federal funding, shifts in state

fiscal conditions, and the upcoming election, all which can have implications for Medicaid spending trends.

Below are some key highlights of an analysis conducted by KFF analyzing Medicaid enrollment and spending trends for FY 2024 and FY 2025 based on data provided by state Medicaid directions:

- Following years of significant growth, Medicaid enrollment declined by -7.5% in FY 2024 and state Medicaid officials expect enrollment to continue to decline by -4.4% in FY 2025. These growth rates reflect the *net* Medicaid enrollment change from year to year including new enrollments, coverage losses due to unwinding, and some "churn" when those who lose coverage re-enroll within a short period of time. The unwinding of the continuous enrollment provision was the largest driver of enrollment declines.
- Total Medicaid spending growth slowed to 5.5% in FY 2024 and is expected to slow further to 3.9% in FY 2025. While state Medicaid officials identified unwinding-related enrollment declines as the most significant factor driving changes in *total* Medicaid spending, they also noted a number of upward pressures on total spending. This included enrollment increases from eligibility changes such as 12-month continuous eligibility for children or overall state or Medicaid eligible population growth, the higher health care needs of enrollees that retained coverage during unwinding, and rate increases.
- As anticipated, state Medicaid spending growth increased sharply in FY 2024 (19.2%) as the enhanced FMAP phased down and expired (after declining earlier in the pandemic despite high enrollment growth). State Medicaid spending growth is projected to slow to 7.0% in FY 2025, only slightly higher than total spending growth as the shifts caused by the enhanced FMAP expiration end.

Medical Costs Covered by Medicaid

Medicaid covers the same kinds of services as Medicare. In most states, it also covers several medical services Medicare does not. One of its best features covers most long-term care, both at home and in nursing facilities. This includes long-term care skilled nursing care and non-medical personal care–such as adult day care and at-home assistance with the activities of daily living (ADLs: Bathing; Dressing; Toileting; Transference; Continence; Eating; and Ambulating). These are the very needs that force many people into nursing homes and keep them there for years.

Medicaid also pays many of the amounts Medicare does not pay in hospital and doctor bills. Specifically, this means Medicaid pays:

- The inpatient hospital insurance deductible and coinsurance amounts that Medicare does not pay.
- The Medicare medical insurance deductible.
- The 20% of the Medicare-approved doctors' fees that Medicare medical insurance does not pay; and

- The monthly premium charged for Medicare Part B medical insurance.

Services Covered in Every State

In every state, Medicaid must cover certain medical services, known as the "essential health benefit" (EHB) programs, paying whatever Medicare does not. They must do so– it's a matter of federal law. These services include:

- Inpatient and outpatient hospital services.
- Physician, midwife, and nurse practitioner services.
- Early and periodic screening, diagnosis, and treatment (EPSDT) for children up to age 21.
- Laboratory and x-ray services.
- Family planning services and supplies.
- Federally qualified health center (FQHC) and rural health clinic (RHC) services.
- Freestanding birth center services (added by ACA).
- Nursing facility (NF) services for individuals age 21+.
- Home health services for individuals entitled to NF care.
- Tobacco cessation counseling and pharmacotherapy for pregnant women (added by ACA); and
- Non-emergency transportation to medical care, inpatient hospital, or skilled nursing facility care.

Optional Services

Many states also cover many other types of medical services that federal law designates as optional. Most states provide prescription drugs. All states provide Medicaid coverage for prescription drugs, though there may be a small copayment for each prescription filled. For people eligible for Medicare and Medicaid (known as "dual eligible"), however, Medicaid no longer covers most drugs. Instead, "*dual eligible*" receive their drug coverage through a separate Medicare Part D plan. In some states, though, Medicaid covers the cost of same prescription and over-the-counter drugs for "dual eligible" that Medicare Part D plans do not cover:

- *Eye Care*. Standard eyesight exams (every one to two years), plus the cost of eyeglasses.
- *Dental Care.* Routine dental care, though the list of dentists whom they're allowed to see may be quite limited; most states also cover the cost of dentures.
- *Transportation.* Non-emergency transport to and from medical care usually with some sort of van service under contract to the county.
- *Physical Therapy*. Most states provide some amount of physical therapy beyond the limited amount covered by Medicare; and
- *Prosthetic Devices*. All states cover the costs of medically necessary prosthetics beyond what is paid for by Medicare.

The types and amount of coverage for other optional services vary widely from state to state. However, these other optional services often include chiropractic care; podiatry; speech and occupational therapy; private-duty nursing; personal care services; personal care and case management services as part of home care, adult day care, hospice care, various preventive, screening, and rehabilitative services; and inpatient psychiatric care for those 65 and older.

Under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSFT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.

Eligibility for Medicaid

To be eligible for Medicaid, an applicant must meet the requirements for an eligibility group that the applicant's state covers under its Medicaid program. We can define an "*eligibility group*" as people who have certain common characteristics, such as being aged or disabled, and who meet certain common requirements, such as having income and assets below certain levels. There are many different eligibility groups in the Medicaid program, and each one has its own set of requirements. As mentioned earlier, states are required to cover some groups but have the option to cover or not cover others.

If a state participates in Medicaid, the following are examples of groups that must be provided Medicaid coverage:

- Poor families that meet the financial requirements (based on family size) of the former Aid to Families with Dependent Children (AFDC) cash assistance program.
- Pregnant women and children through age 18 with family income at or below 133% of the federal poverty level (FPL).
- Low-income individuals who are age 65 and older, or blind, or who are under age 65 and disabled who qualify for cash assistance under the Supplemental Security Income (SSI) program.
- Recipients of adoption assistance and foster care (who are under age 18) under Title IV–E of the Social Security Act.
- Certain individuals who age out of foster care, up to age 26, and do not qualify under other mandatory groups noted above; and
- Certain groups of legal permanent resident immigrants (e.g., refugees for the first seven years after entry into the United States; asylees for the first seven years after asylum is granted; lawful permanent aliens with 40 quarters of creditable coverage under Social Security; immigrants who are honorably discharged U.S. military veterans) who meet all other financial and categorical Medicaid eligibility requirements.

Examples of groups that states may provide Medicaid include:

- Pregnant women and infants with family income between 133% and 185% of the FPL.
- Certain individuals who qualify for nursing facility or other institutional care and have incomes up to 300% of SSI benefit level, referred to as "the 300 percent rule;"
- "*Medically needy*" individuals who are members of one of the broad categories of Medicaid covered groups (i.e., are aged, have a disability, or are in families with children), but do not meet the applicable income requirements and, in some instances, assets requirements for those eligibility pathways; and
- Working people with disabilities.

Since 2014, states have had the option to expand Medicaid eligibility beyond the historical categorical eligibility groups to all citizens under age 65, who otherwise are not eligible for Medicaid with income at or below 133% of FPL (i.e., the ACA Medicaid expansion). The income limit is effectively 138% of FPL (after adjusting for a 5% income disregard applicable if individuals are at the highest income limits for coverage).

General Requirements

For the most part, to be eligible for Medicaid, an applicant must be one of the following:

- Age 65 or older.
- Have a permanent disability as the Social Security Administration defines that term.
- Blind.
- Pregnant; or
- A child, or the parent or caretaker of a child.

In addition, the applicant must meet certain other requirements, such as:

- Be a U.S. citizen or meet certain immigration rules.
- Be a resident of the state where applied; and
- Have a Social Security number.

States are permitted to apply to CMS for a waiver of federal law to expand health coverage beyond the mandatory and optional groups listed above and in the federal statute.

Requirements for Coverage

Even if a particular medical service or treatment–such as a prosthetic device–is generally covered by Medicaid, the beneficiary (patient) must make sure that the care was prescribed by a doctor, administered by a provider who participates in Medicaid, and determined to be medically necessary.

Care Must Be Prescribed by Doctor

A doctor must prescribe the medical service the beneficiary receives. For example, Medicaid will not pay for chiropractic services or physical therapy the beneficiary seeks independently. If it pays for certain prescription medications not covered by Medicare, it might not pay for an equivalent medicine they could buy over the counter.

For services in which a doctor is generally not involved–such as regular eye exams or dental care–Medicaid may place restrictions on how often the beneficiary can obtain the service and who can authorize it. Medicaid will cover some services for those who qualify as Medically Needy (discussed below) only if the care is provided by certain public health hospitals, clinics, or agencies.

Provider Must Be Participating in Medicaid

The beneficiary (patient) must receive treatment or other care from a doctor, facility, or other medical provider participating in Medicaid. The provider must accept Medicaid payment–or Medicare plus Medicaid–as full payment. If the beneficiary saw a non-physician such as a physical therapist or chiropractor or was visited by a home care agency, that Medicaid must approve provider.

Not all doctors and clinics accept Medicaid patients. They can get referrals from their local social welfare office. Before they sign up with any doctor or other provider, they should ask whether Medicaid payment is accepted.

Treatment Must Be Medically Necessary

Medicaid must approve all care as medically necessary. For inpatient care, the approval process is like the one used for Medicare coverage. Their doctor sets the approval process in motion by requesting their admission to a hospital or other facility. The beneficiary won't need to be involved. In fact, they won't even hear about it unless the facility decides they should be discharged before their doctor thinks they should.

The beneficiary must get prior approval from a Medicaid consultant before they obtain certain medical services. The rules vary from state to state, requiring prior approval for such services as elective surgery, some major dental care, leasing of medical equipment, and non-emergency inpatient hospital or nursing facility care.

If a particular medical service requires prior Medicaid approval, the beneficiary's doctor or the facility will contact Medicaid directly. The beneficiary may be asked to get an examination by another doctor before Medicaid approves the care, but this does not happen often. If they have questions about the approval process, they should discuss it with both their doctor and a Medicaid worker at their local social service or welfare office. The beneficiary should ask what Medicaid considers most important in deciding on the medical care they are seeking. Then they should relay that information to their doctor so that the doctor can provide the necessary information to Medicaid.

Medicaid Coverage Groups

You should be aware of two pathways or groups because they are most used to make people eligible for Medicaid, especially long-term care services. These Medicaid coverage groups are assigned one of two broad sections:

- Categorically Needy (CN); and
- Medically Needy (MN).

Below we will discuss the specific Medicaid eligibility rules for the aged (65 and older).

Categorically Needy

Initially, Medicaid required participating states to provide medical assistance to persons who received cash payments under one of four welfare programs established elsewhere in the Social Security Act. These programs were:

- Old Age Assistance.
- Aid to Families with Dependent Children (AFDC).
- Aid to the Blind; and
- Aid to the Permanently and Totally Disabled.

Persons receiving aid under one of these four programs were referred to as the "*categorically needy*."

SSI Based Standards

In 1972, Congress restructured the non-AFDC welfare programs and replaced three of the four "categorical assistance" programs with a new program called Supplemental Security Income (SSI) for the Aged, Blind and Disabled, 42 U.S.C. 1381. Under SSI, the federal government assumed responsibility for both funding payments and setting standards of need. Congress retained the requirement that all recipients of categorical welfare–assistance–now including the new SS program–were also entitled to Medicaid. Because the federal SSI eligibility standards were more lenient than the previous eligibility standards in some states, the number of individuals eligible for Medicaid would have increased significantly.

To qualify for Medicaid as "*Categorically Needy*," the applicant's income and assets must be at or below certain dollar amounts. Most states use the same income and asset limits set by the federal *Supplemental Security Income* or SSI program. In most states, the applicant can automatically receive Medicaid if they are eligible for SSI assistance.

To be eligible for SSI assistance in 2025, an applicant usually cannot earn more than $967 per month (up from $943/month in 2024) or $1,450/month (up from $1,415/month in 2024) for an eligible individual with an eligible spouse, and $484/month (up from

$458/month in 2024) for an essential person. According to SSA, the average SSI payment in 2024 (adults) was $967 per month, an eligible couple was $1,450 and an essential person was $484/month. Also, they cannot possess cash and other assets (resources) of more than $2,000 for an individual and $3,000 for a couple.

Other states establish their own state standard Medicaid limits. States have gone in all directions when establishing their own Medicaid standards. In a few states, the standards are slightly less difficult to meet than SSI standards. In some other states, the standards are stricter, including a dollar limit on the value of an applicant's home and lower limits on the values of their automobile and other property. The applicant can find out their state's standards by contacting their local county department of social services or welfare.

Finally, some states set eligibility for certain benefits, such as eligibility for Medicaid coverage of long-term care services (nursing home, HCBS, and PACE), an individual must have income at or below 300% of the SSI one-person standard (for 2025, that amount is $967 month x 3 = $2,901/month (up from $2,829/month in 2024). This cap changes yearly since the SSI maximum is adjusted yearly for inflation. Unless, of course, the applicant pays the excess income (cannot be funded with assets) above $2,901 into a "(d)(4)(B)" or "*Miller*" trust (for a full discussion of Miller Trusts see Chapter 18).

Once eligibility for Medicaid is determined, coverage generally is retroactive to the third month prior to application. Medicaid coverage generally stops at the end of the month in which a person no longer meets the criteria of any Medicaid eligibility group.

Table 17.1 shows the 23 states that impose an "*income cap*" on eligibility for older persons (age 65 and older).

Table 17.1
Income Cap States

Alabama	Idaho	Oklahoma
Alaska	Iowa	Oregon
Arizona	Kentucky	South Carolina
Arkansas	Louisiana	South Dakota
Colorado	Mississippi	Tennessee
Delaware	Nevada	Texas
Florida	New Mexico	Wyoming
Georgia	New Jersey	

Section 209(b) States

Fearing that states would withdraw from the Medicaid program because of the expanded coverage, Congress enacted what became known as the "Section 209(b) option" [42 U.S.C. 1396a(f)]. Under this option, states can opt out of the requirement of providing Medicaid automatically to persons who receive SSI and elect instead to provide Medicaid assistance only to those individuals who would have been eligible under the state

Medicaid plan in effect on January 1, 1972. The 209(b) option thus "allows the states to avoid the effect of the link between the SSI and Medicaid programs."

Eleven states have developed their criteria and are known as the “209(b) states” (see Table 17.2). They are called “209(b) states” because it was section 209(b) of the Social Security Amendments of 1972 that gave states the option of using their criteria for Medicaid.

Table 17.2
“209(b)States”

Connecticut	Hawaii	Illinois	Minnesota
Missouri	North Dakota	New Hampshire	

The exact income, resource, and disability criteria for Medicaid eligibility differ from state to state among the 209(b) states. Except for Hawaii, however, the state's 209(b) income standards are close to the federal SSI income limit. Some of the 209(b) states also have different rules than Social Security for what is considered countable income.

About half of the 209(b) states use the federal SSI resource limit as the asset limit for Medicaid, and half use a lower limit (and two use a higher limit). All 209(b) states must allow Medicaid applicants to deduct medical expenses from their income when determining their eligibility for Medicaid. This "spend-down" ability is important protection. It allows many SSI recipients to meet the more restrictive income limits of some 209(b) states. For example, if an applicant's countable income is $200 more than the state's maximum allowable income for Medicaid eligibility, they would still qualify if they had to pay for at least $200 in medical expenses during the month.

Therefore, under the Medicaid program, States are either "SSI States" or "209(b) States," depending upon whether they provide Medicaid assistance to all SSI recipients or only to those individuals who meet the state's own eligibility standards.

Medicaid Eligibility Rules for Married Spouses

Eligibility rules are more complicated when the applicant is married because assets of both the spouse receiving care (the “institutionalized spouse”) and the spouse living at home (the “community spouse”) must be considered. To understand these rules, it is helpful, to begin with, an understanding of two traditions or principles that influence the availability of Medicaid.

The first principle is that spouses are financially responsible for one another. The financial resources of the spouse who is not applying for Medicaid (the "well spouse" or the "community spouse") are viewed as available to the institutionalized spouse to help pay for their care before Medicaid pay.

The second principle is that the first principle should not be carried too far. Holding the community spouse totally financially responsible for the institutionalized spouse would (and under older versions of Medicaid, did) lead to severe impoverishment of many community spouses. Concern about this phenomenon is acute in nursing home cases, where the cost of care can consume the couple's entire life savings in a matter of months.

In 1988, Congress passed the Medicare Catastrophic Coverage Act (MCCA), Pub. L. No. 100–360, 102 Stat. 683 [42 U.S.C. § 1396], to protect community spouses from 'pauperization' while preventing financially secure couples from obtaining Medicaid assistance. To achieve this aim, Congress installed a set of intricate and interlocking requirements with which states must comply in allocating a couple's income and resources." In particular, the MCCA allows the community spouse to keep a portion of the couple's assets–this is known as the *Community Spouse Resource Allowance* (CSRA)–without affecting the institutionalized spouse's Medicaid eligibility.

Medicaid Eligibility for Single Person

For 2025, a significant majority of states have a maximum Countable Asset limit of $2,000 for single individuals applying for Institutional Medicaid. A handful of states, meanwhile, have modestly higher maximum Countable Asset limits of between $5,000 and $10,000. New York is the most generous state in this regard, but even New York has a maximum Countable Asset limit of just under $30,182 for single individuals applying for Institutional Medicaid.

To view individual state limits, you can go to: State Specific Medicaid Eligibility Requirements

Assets, though, are only half of the equation. To qualify for Medicaid, an individual must also meet income eligibility requirements. More specifically, Medicaid enrollees must have either limited income or, in some states, medical expenses that 'eat up' most of their (higher) income.

In 2025, to qualify for Institutional Medicaid under the 'regular' rules in most states, an individual must have a monthly income of $2,901 or less. Some states, on the other hand, have income limits closer to $1,000. In the end, though, for individuals who will be receiving Institutional care, it's largely a matter of semantics because these income limits are *not* the amount of monthly income an individual can keep, but rather, simply the income levels at which point they can become eligible for Medicaid. If enrolled in Medicaid, most of that income (save for a maximum of about $150 per month – and in some states, less than one-quarter of that!) must be used to pay for care.

In more than 30 states, individuals with higher income can also qualify for Medicaid through what are known as "*Medically Needy Income Limits*," discussed below. In short, these limits look at an individual's total income and their total medical bills. If, after subtracting an individual's total medical bills, their net income is less than their specified threshold (which ranges from about $100 to about $1,100 per month, depending on their

state of residence or, in limited cases, their specific location within a state), they will be eligible for Medicaid, regardless of how high their initial income (before medical expenses) was.

Any way you slice it, the point is that to qualify for Medicare, an individual must have extremely limited assets, and they must be using most of their income for medical expenses.

Treatment of Assets

The starting point in the treatment of assets for married couples is that all assets owned by either spouse are considered available to the institutionalized spouse for purposes of Medicaid eligibility. Some assets, such as a principal residence occupied by the community spouse, are not counted, based upon the same rules for countable and non-countable assets applied to unmarried applicants. Assets cannot be left out of the picture on the grounds that they belong exclusively to the spouse who is not applying for Medicaid.

The Community Spouse Resource Allowance (CSRA)

After adding together all countable marital assets, the state Medicaid agency then determines what share of those assets the community spouse will be allowed to keep. At the same time, the other receives Medicaid nursing home benefits. This figure, based upon a combination of federal and state laws, is called the *Community Spouse Resource Allowance*, or *CSRA*.

The effect of the CSRA is to reduce the assets that are considered available to the institutionalized spouse:

> ***For Example**:* Suppose a couple has a combined total of $100,000 of countable assets. If they live in a state that allows the community spouse to keep the first $100,000, all assets will be attributed to the community spouse. No assets, therefore, will be attributed to the institutionalized spouse. They will immediately qualify for Medicaid as an applicant has less than $2,000 in resources.

Not all states would allow the community spouse to keep the first $100,000 as a CSRA. The exact rules for attributing a couple's assets vary from state to state, some being more generous than others.

There is, however, a federal minimum and maximum CSRA to which all states must adhere. For FY 2025, the Centers for Medicare and Medicaid Services (CMS) increased the Medicaid numbers for the minimum CSRA to $31,584 (up from $30,828 in 2024) and the maximum CSRA to $157,920 (up from $154,140 in 2024).

Between the minimum and the maximum figures, states can use a variety of methods to allocate assets. Some states allow the community spouse to keep all countable assets up

to the federal maximum. These states are known as "*straight deduction*" states. Only assets above the cap ($157,920 in 2025) are attributed to the institutionalized spouse.

Note: In straight deduction states, the minimum CSRA never comes into play.

Other states use more complicated formulas. Many states, for example, do not increase the community spouse's share above the minimum amount until an equal amount has been attributed to the institutionalized spouse. These states are known as "*one-half deduction*" states. If the couple has more than double the minimum CSRA, additional assets are divided equally between the spouses until the maximum CSRA has been attributed to the community spouse.

Take the couple with the $100,000. In a "*one-half deduction state*," the CSRA calculation would take the total countable resources and divide them by 2 to yield the CSRA of $50,000. When the countable resources exceed twice the maximum, the maximum CSRA is used in a "one-half deduction" state. For instance, a couple with $300,000 would only be able to set aside $157,920 for the CSRA in 2025. The remaining assets would be exposed to a spending down. The minimum CSRA is a floor and only factors in when the total amount of assets divided by 2 falls below the minimum.

> ***For Example:*** If a couple has $40,000, then the CSRA would not be $20,000 because that's below the minimum. The CSRA, in that case, would become the minimum $31,584 in 2025.

Assets attributed to the institutionalized spouse under any of the formulas used by the states must be spent on nursing home care before Medicaid is approved. When all but $2,000 has been spent, the institutionalized spouse will qualify for Medicaid.

Once the couple can show that they have spent all excess assets, the individual should qualify for Medicaid. Income or new assets received by the community spouse after Medicaid is approved will not affect eligibility. If the institutionalized spouse receives new assets, however, eligibility will be affected. The assets may have to be spent, or the couple can request a revised (increased) CSRA, which is explained below.

The institutionalized spouse has 90 days after obtaining eligibility to transfer to the community spouse enough assets to satisfy her CSRA. These transfers incur no penalty.

The Assessment

The state Medicaid agency must provide institutionalized individuals with an "assessment" of eligibility if requested by the individual or spouse. An assessment does two things. First, it makes sure that all assets are counted as of the date of admission to the nursing home, not the date of the Medicaid application.

It is important to count all assets as of the date of admission to the nursing home to ensure that the community spouse gets their full CSRA. The couple usually begins spending assets after the ill spouse is admitted to the nursing home. Couples with a

modest amount of assets often pay privately for a while before considering Medicaid. Such delays would create problems if assets were assessed as of the date of the application instead of the date of admission to the nursing home.

> ***For Example:*** **If** a couple's assets were assessed one year after admission, the amount would be thousands of dollars less than it was on the date of admission. The couple might already have spent part of the community spouse's CSRA on the nursing home by that time. It would be difficult and administratively costly for them to get their money back if that happened.

To ensure that the CSRA is not spent before Medicaid is applied for, the state agency must look at the amount of assets on the date of admission to the nursing home, not the amount left when the couple applies for Medicaid. For this reason, the assessment often is referred to as a "*snapshot*" of the couple's assets on the date of admission to the nursing home.

The other purpose of the assessment is to tell the couple exactly what amount of assets the agency considers available to the institutionalized spouse to pay for care. These are considered *"excess assets*." Excess assets must be spent before the institutionalized spouse becomes eligible for Medicaid.

If the couple does not request an assessment separately, they will be done when they apply for Medicaid. Again, the purpose of assessing a separate procedure is twofold. First, it determines the amount of assets as of the date of admission to the facility instead of the date of application for Medicaid. Second, it informs the couple of the amount of excess assets (if any) that must be spent before the institutionalized spouse becomes eligible for Medicaid.

Treatment of Income

Income is treated quite differently from assets for married couples. Unlike assets, the income of the community spouse is not considered available to the institutionalized spouse. As explained below, there are provisions for using the institutionalized spouse's income to support the community spouse, but not vice versa. The separate income of the community spouse is always his or hers to keep.

As a rule, the institutionalized spouse's income must go to the nursing home as a "*patient paid amount*," or "*PPA*." There are, however, a few exceptions, which are calculated as deductions from the PPA.

A person who lives in a nursing home can keep a minimum personal needs allowance (PNA). Medicaid's PNA is the amount of monthly income a Medicaid-funded nursing home resident can keep of their personal income. Since room, board, and medical care are covered by Medicaid, most of one's income must go towards the cost of nursing home care. The PNA intends to cover the nursing home resident's personal expenses, which are not covered by Medicaid. This may include but is not limited to haircuts, vitamins, clothing, magazines, and vending machine snacks.

Federal law requires that a Medicaid-funded nursing home resident receives a personal needs allowance. Authorized by the Supplemental Security Act Amendments of 1972, and enacted in 1974, the federally mandated PNA was set at $25 / month. The 1987 Omnibus Budget Reconciliation Act, effective in 1988, increased it to $30 / month, where it remains now. In addition to the required $30 / month personal needs allowance, a state can supplement this amount to allow nursing home residents a higher personal needs allowance. The maximum allowable PNA is $200 / month. While the PNA amount varies by state, it is between $30 / month and $200 / month in all states.

Under certain circumstances, if a nursing home resident does not have their own monthly income, the personal needs allowance is provided by the state in which one resides.

Veterans who do not have a spouse or dependent child and receive a VA enhanced pension, such as the Aid & Attendance (A&A Pension), might receive a higher monthly personal needs allowance than the state's listed amount above. When a veteran resides in a Medicaid-funded nursing home facility, their pension amount is reduced to $90 / month. If a state's personal needs allowance is under $90 / month, the state might increase the PNA to $90 / month to allow the veteran to keep their reduced pension. Illinois is one such example. The state has a $30 / month personal needs allowance and increases the personal needs allowance to $90 / month for a veteran in this situation. To be clear, the $90 / month reduced pension becomes the individual's personal needs allowance. Other states disregard the $90 / month reduced pension altogether and let the veteran keep it along with a monthly personal needs allowance (PNA)). Texas, in some cases, will allow a veteran to keep both the $90 / month reduced pension and the state's $60 / month personal needs allowance.

To view of the various state's PNA go to:
https://www.medicaidplanningassistance.org/personal-needs-allowance/

While not technically a PNA, a few states, such as California, allow an individual residing in a Medicaid-funded nursing home to retain some of their personal income to maintain their home. This home maintenance allowance is limited to 6 months and is intended to keep one's home maintained for their return. To receive this allowance, the nursing home resident cannot have a spouse or relative living in the home, and it must be determined by a physician that they will likely return home within 6 months. To be clear, this allowance is in addition to CA's $35 / month personal needs allowance.

Note: There is no federally set rule as to how often a state must increase their personal needs allowance. Four states, Alabama, Illinois, North Carolina, and South Carolina, continue to use the 1988 federally set minimum personal needs allowance of $30 / month. This means the PNA in these states has not changed in over 30 years. Other states periodically increase their PNA. For instance, Georgia's personal needs allowance was set at $50 / month for many years. In 2018, it increased to $65 / month, and in 2019, it increased to $70 / month, where it has remained. Massachusetts is another example. The state increased their PNA to $72.80 in 2007 and it has since remained unchanged. Other states increase their PNA on an annual basis. One such state is Arizona, which has their

personal needs allowance set at 15% of the Federal Benefit Rate (FBR). Since the FBR increases annually in January, the state's personal needs allowance also increases each year accordingly. Colorado also increases their personal needs allowance annually.

The income deduction for the community spouse is more complicated, as explained below.

The Minimum Monthly Maintenance Needs Allowance

Medicaid establishes a minimum income standard for the community spouse, called the "*minimum monthly maintenance needs allowance*," or "MMMNA." This provision is set at one-and-one-half times the Federal Poverty Level (FPL) for a single person living alone. The minimum maintenance needs allowance is set mid-year, and these numbers remain in effect until June 30 of the following year. From July 1, 2025, through June 30, 2026, the minimum monthly maintenance needs allowance (Minimum MMNA) will increase to $2,643.75 (up from $2,555/month). Due to the higher cost of living, Hawaii has (MMMNA) of $3,040.00, and Alaska's minimum monthly maintenance needs allowance is $3,303.75/month. The maximum monthly maintenance allowance is determined each year at the beginning of the year. For 2025, the maximum monthly maintenance needs allowance is $3,948 (up from $3,853.50 in 2024).

Note: The amount of the MMMNA can be increased if the community spouse can show at a hearing that their shelter expenses are more than 30% of the minimum allowance. For July 1, 2025–June 30, 2026, the community spouse monthly housing allowance is $794 (30% of $2,643.75) for all states except Alaska ($1,189) and Hawaii ($995). The additional need is referred to as the "*Excess Shelter Allowance*." It is credited to the community spouse as an additional income allowance.
MMMNA Calculation Example*:*

> John and Rose live in Florida, and John has Alzheimer's disease that has progressed to the stage where he requires 24-hour supervision. Therefore, he has relocated to a Medicaid funded nursing home. John has $2,700/month in income, and Rose's monthly income is $830/month. In Florida, the Minimum Monthly Maintenance Needs Allowance is set at $2,645 a month. The Maximum Monthly Maintenance Needs Allowance is $3,948. Since Rose's income of $830/month is under the MMMNA of $2,644, she is automatically entitled to $1,814/month of John's income to bring her income level up to the MMMNA of $2,644/month.
>
> In Florida, the Community Spouse Monthly Housing Allowance is set at $740 $794/month, and the Standard Utility Allowance (SUA) is $419/month. **Note**: The Florida personal needs allowance is $130.00 per month.
>
> Rose has a mortgage and real estate tax payment of $1,650/month and a homeowner's insurance payment of $100/month, for a total of $1,750/month. Rose pays for the heating and cooling, so an SUA of $419/month is also added to her monthly shelter costs. ($1,750 + $419 = $2,169/month in total shelter costs). Since her total monthly shelter cost is over the standard monthly housing

allowance of $790, this figure is deducted from Rose's monthly shelter costs. ($2,169/month minus $790/month = $1,379/month in which Rose is entitled in shelter costs).

As mentioned above, Rose is entitled to $1,814/month to bring her income level up to the MMMNA of $2,644. With the additional $1,379/month for excess shelter costs, this brings the total amount to $3,193/month ($1,814 + $1,379). However, with Rose's own income ($830/month) and the income in which she might be entitled to from her institutionalized spouse ($1,814 to reach the MMMNA and $1,379 in excess shelter cost = $3,193), her total monthly income would come to $4,023 Since this figure is more than the estimated Maximum Monthly Maintenance Needs Allowance of $3,948/month in Florida, she is entitled to receive $3,118 of her husband's income.

By requiring the MMMNA to be determined and using this as a minimum income level for the community spouse, Medicaid prevents impoverishment in cases where the community spouse's separate income is less than the MMMNA.

The Revised Community Spouse Resource Allowance

Upon learning the amount of the MMMNA, the couple may be allowed to increase the community spouse's CSRA if their income is less than the MMMNA.

Depending upon local state rules, the community spouse may retain excess assets as a "*revised CSRA*," based upon calculations similar to the above formula. Each state uses its own interest rate, and some states now deny a "*revised CSRA"* if the institutionalized spouse has income that can be used to supplement the community spouse's income. But the community spouse may benefit from the "*revised CSRA*" procedure under appropriate circumstances.

A "*revised CSRA*" requires that one of the spouses request a "fair hearing," or appeal when Medicaid is denied based on excess assets. The federal Medicaid statute requires notice of the right to request such a hearing stated in the notice of denial of benefits. The notice also must explain the method used to calculate the CSRA and the right to request a hearing to review the amount of the MMMNA.

Medically Needy Program

The *Medically Needy (MN) Program* offers states the option to extend Medicaid coverage to individuals with high medical expenses who would otherwise be ineligible for Medicaid because their incomes exceed eligibility limits. By subtracting incurred health care expenses from their income, individuals are permitted to "*spend down*" to Medicaid eligibility. The MN option is complicated for beneficiaries to understand and for state Medicaid programs to administer. Still, the opportunity to spend down is particularly important to elderly individuals residing in nursing facilities and children and adults with disabilities who live in the community and incur high health care expenses. Currently, 32

states and the District of Columbia have Medicaid medically needy programs covering 3 million people (see Table 17.3). The most expensive among the medically needy population are those who are dually eligible for both Medicaid and Medicare.

Table 17.3
Medically Needy States

California	Maine	New York	Virginia
Connecticut	Maryland	North Carolina	West Virginia
District of Columbia	Massachusetts	North Dakota	Washington
Hawaii	Minnesota	Pennsylvania	Wisconsin
Illinois	Montana	Rhode Island	
Indiana	Nebraska	Utah	
Kansas	New Hampshire	Vermont	

Medicaid Needy Eligibility

The Medically Needy (MN) program is a federal and state-funded Medicaid program for persons who are aged, blind, or have disabilities, pregnant women, or children with income above "*categorically needy*" (CN) limits. The MN program provides slightly less medical coverage than CN and requires greater financial participation by the beneficiary. As discussed above, the "*medically needy*" program provides a pathway to Medicaid coverage for people with extensive health care needs yet start with too much income to qualify for cash assistance and, therefore, Medicaid.

The role of the "*medically needy*" program is unique in that it provides a last chance opportunity for becoming eligible for Medicaid for individuals not eligible as "*categorically needy*." As discussed above, under current law, states are required to cover certain federal core groups to receive federal Medicaid matching funds. States also have flexibility to expand Medicaid eligibility beyond federal minimum standards to cover additional "optional" groups and receive federal Medicaid matching funds for the costs of their services.

Medically needy coverage is generally optional for states–it is allowed but not required. However, medically needy coverage is mandatory to the extent that a state's historical 209(b) obligation requires the state to maintain a medically needy program that was in place as of January 1, 1972. As with other pathways to eligibility, to be eligible as "*medically needy,"* a person must meet the general eligibility requirements such as being aged, blind or disabled.

People eligible as "*medically needy"* have too much income to qualify for Medicaid through any other pathway. However, they can still qualify for Medicaid as medically needy by "spending down" the income above their state's income limit.

Spend-Down

Spend-down is like an insurance deductible. It's the process used to determine the client's liability for the cost of medical care. An applicant must incur medical expenses equal to their excess income (spend-down or liability) before medical benefits are authorized. The spend-down liability is the applicant's financial obligation and can't be paid by the state. The amount to be computed is the applicant's base period, consisting of three or six consecutive calendar months. Depending on when the applicant's incurred medical expenses meet the spend-down liability, the applicant may get medical benefits for all or part of the base period.

States may choose to provide medically needy coverage to one or more groups:

- The elderly.
- Individuals with disabilities.
- Parents and caretaker relatives; and
- Certain other financially eligible children up to age 21.

States must use a single income eligibility standard for all medically needy recipients (regardless of whether they are families or SSI-related) that considers the number of persons in the assistance unit. This single income standard is called the "*medically needy income level*" (MNIL).

Individuals who have incomes above the state's MNIL but fall below that level once their medical expenses are deducted can qualify for Medicaid coverage as medically needy through spend-down.

To spend down, an individual must incur (but not necessarily pay) medical and remedial care expenses that bring their countable income below the MNIL. Federal rules identify expenses that count toward the spend-down requirements, including expenses for Medicare and other health insurance premiums, deductibles, and coinsurance; expenses for necessary medical and remedial services recognized under state law but not included in the Medicaid state plan; and expenses for necessary medical and remedial services that are included in the Medicaid state plan, including those that exceed limitations on amount, duration, or scope of services. Several factors affect the determination of Medicaid eligibility through spend-down, including:

- Income eligibility.
- Budget period; and
- Pay-in spend-down.

Income Eligibility

There are two components to determining income eligibility, the income standard, and the income methodology. The standard is the maximum amount of countable monthly

income an individual can have and still be eligible for Medicaid. The methodology determines how much of a person's income is counted toward the income standard.

Federal regulations require a state to use a single income standard for all medically needy beneficiaries in most circumstances. States have broad discretion in setting the income standard. However, they can only receive federal matching payments for individuals whose income is below a maximum of 133 percent of the state's 1996 AFDC payment level. States can adjust this level for inflation, but adjustments cannot exceed increases in the consumer price index. The MNIL can also vary between urban and rural areas based on differences in housing costs. States are permitted, but not required, to increase the MNIL as family size increases. Still, they are prohibited from decreasing MNIL as family size increases. In most states, the income standard must be set at an amount no lower than the lowest income standard used to determine eligibility under the related cash assistance programs. The 209(b) states are allowed an exception to establish a more restrictive income standard for medically needy blind and disabled individuals than for medically needy families with children.

States have flexibility in establishing income methodology, and the rules that each state chooses to apply can vary dramatically. Elements of the methodology include definitions of income; exclusions or disregards of income; composition and number of persons included in the budgetary unit, deeming of income from spouses and parents; treatment of regular and periodic income; and ownership of income. Except for 209(b) states, the methodology used to count income can be no more restrictive than those used in the closely related cash assistance program. Therefore, a state may have a single income standard for all groups but use a different methodology for determining whether income falls below the standard for children, parents, people with disabilities, and the elderly. However, states are still bound by the 133 percent of AFDC payment standard constraint.

Budget Period

In determining eligibility, the state selects a budget period of between one and six months, during which time an applicant will be assessed to determine whether they meet their spend-down obligation. If, after deducting medical costs, the individual's income is below the state established MNIL, the individual will qualify for Medicaid coverage for the remainder of the period. There is no Medicaid coverage until the point in the spend-down period that the individual has hit the MNIL and continues through the last day of the state's spend-down period.

Depending on an individual's circumstance and whether their medical expenses are incurred on an ongoing basis, the length of the budget period can make it easier or harder for an individual to meet the spend-down requirement. States are permitted to use more than one budget period.

For example, the state could establish one budget period for institutionalized individuals and another for non-institutionalized individuals. Further, the state could establish two budget periods for non-institutionalized individuals. In this case, however, the state must allow the applicant to select which budget period will be applied.

The length of the budget period can pose a significant barrier to Medicaid coverage for people in certain circumstances, including people in need of a home and community-based services or persons desiring to live in an assisted living center. This is because the full spend-down for the length of the budget period must be incurred before Medicaid coverage begins. In this case, either the individual needs to pay the full spend-down with their funds or the provider must be willing to wait for payment until Medicaid coverage begins. Institutional providers and larger providers may be more willing to begin caring for an individual before they are determined to be eligible for Medicaid, something that smaller, community-based providers cannot do.

There are advantages to both a short and a long budget period. Presumably, a long budget period is administratively preferable. However, a shorter budget period for many beneficiaries makes it easier to qualify for Medicaid because they only need to meet the spend-down requirement one month at a time. However, a longer budget period may be preferable for some individuals if they have recurring high-cost health conditions. In this case, they may prefer to meet their spend-down and then have a longer period of Medicaid coverage before having to spend down once again.

Table 17.4 shows an example of how the spend-down amount is calculated. Assume a state has a 6-month spend-down period. The applicant has a monthly income of $650, and the eligibility standard is $450 a month. To meet the eligibility level, the applicant must incur health-related expenses of $1,200 ($200 x 6) before she is eligible for Medicaid. The applicant must incur enough health expenses to reduce her income to the eligibility standard each month to remain qualified.

Pay-In Spend-down

States can provide an alternative method for individuals to meet the spend-down requirement with *Pay-in Spend-down*. This involves individuals making a cash payment to the state to satisfy the spend-down requirement.

> ***For Example:*** If an individual has a spend-down obligation of $500, which is partially satisfied through incurring $300 of medical expenses, the state can accept a cash lump sum or installment payment of $200 for the balance.

It can be beneficial to allow individuals to use a pay-in spend-down. If an individual pays in, they can be eligible for Medicaid before any medical expenses are incurred. This would mean that all expenses are billable at Medicaid payment rates. If an individual must incur expenses before they are eligible, then the services would not be billed at Medicaid rates, or they would not be eligible for discounts and rebates negotiated by Medicaid.

The following states utilize the pay-in option: Illinois, Minnesota, Missouri, Montana, New York, Ohio, and Utah.

Table 17.4
Spend Down Example for the Medically Needy

Individual's Countable Monthly Income	$650
State's Medically Needy Monthly Income Limit	$450
Income Over State Limit	$200
State Spend-Down Period	6 months (varies by state from 1–6 months)
Individual's Spend-Down Amount	$1,200 Income over state's limit times spend down period ($200 x 6 months)

Costs of Medicaid Coverage

Almost all Medicaid-covered care is free. Medicaid also pays the beneficiary's Medicare premiums, deductibles, and copayments. However, there are a few circumstances in which they might have to pay small amounts for Medicaid-covered care.

No Payments to Medical Providers

Hospitals, doctors, and other medical care providers who accept Medicaid patients must accept Medicare's approved charges–or the amount approved directly by Medicaid if Medicare does not cover it–as the total allowable charges. They must accept as payment in full the combination of payments from Medicare and Medicaid or Medicaid alone; they cannot bill the beneficiary for 15% more than the Medicare-approved amount (which they could do if the beneficiary were not on Medicaid).

Fees to States for Medicaid Services

Federal law permits states to charge small fees to people who qualify for Medicaid as Medically Needy. However, if a beneficiary qualifies as Categorically Needy, states can charge them a fee-only for optional covered services. State Medicaid charges will take one of three forms: an enrollment fee, a monthly premium, or copayment.

Enrollment Fee

Some states charge a small, one-time-only fee when Medically Needy people first enroll in Medicaid. This fee cannot be charged to people who are considered Categorically Needy.

Monthly Premium

States are permitted to charge a small monthly fee to people who qualify for Medicaid as Medically Needy. The premium may be charged whether Medicaid services are actually used that month. The amounts vary with income and assets, but usually come to no more than a few dollars.

Copayments

State Medicaid programs are permitted to charge a copayment for each Medicaid-covered service a beneficiary receives. A copayment can be charged to Medically Needy for any service and the Categorically Needy for optional services.

In July 2013, CMS issued revised regulations on Medicaid premiums and cost-sharing. The new rule establishes a uniform maximum copayment amount of $4 for outpatient services and $75 per inpatient admission for those with income below 100% FPL. It also permits states to charge these individuals up to $8 for non-preferred drugs and non-emergency use of the emergency department; states can charge higher cost-sharing amounts for some services to those with income above 100% FPL, within federally specified parameters. The prohibition against premiums for those at or below 150% FPL, the cost-sharing exemptions mentioned above, and the 5% aggregate cap on premiums and cost-sharing remain in place.

The Deficit Reduction Act (DRA) of 2005

With the passage of the Deficit Reduction Act (DRA) of 2005, 42 U.S.C. § 1396p, signed into law by President George W. Bush, the federal government sought to make significant changes to Medicaid's long-term care rules, including:

- The look-back period.
- The transfer penalty start date.
- The undue hardship exception.
- The treatment of annuities.
- Community spouse income rules.
- Home equity limits.
- The treatment of investments in continuing care retirement communities (CCRCs).
- Promissory notes and life estates; and
- State long-term care partnership programs.

Following is a summary of the Medicaid laws before and after the enactment of the DRA in these areas. For the status of the rules in your client's state, you should check with a qualified Elder Law attorney.

The Look-Back Period [Section 6011]

A person applying for Medicaid coverage must disclose all financial transactions they participated in during a set period of time-frequently called the "*look-back period*." The state Medicaid agency then determines whether the Medicaid applicant transferred any assets for less than fair market value during this period. Congress does not want a person to be able to give away all their assets one day and then qualify for public benefits the next.

The DRA extends Medicaid's "*look-back period"* for all asset transfers from three to five years. Previously, the agency reviewed transfers made within 36 months of the Medicaid application (60 months if the transfer was to or from certain kinds of trusts). Now, the look-back period for all transfers is 60 months. The extension of the look-back period will make the application process more difficult. It could result in more applicants being denied for lack of documentation, given that they will need to produce five years' worth of records instead of three. The look-back period is being implemented differently in different states. Some states, like New York, are phasing in the 60-month look-back period. According to these states, the look-back period cannot be greater than 36 months until at least February 2009, the first point when an individual could possibly have made a transfer that occurred more than 36 months after the DRA enactment. Other states had sidestepped the issue or looked at the past 60 months of transfers for all applications filed after the enactment of the DRA (Feb. 8, 2006) regardless of when the transfer occurred.

The Penalty Period Start Date [Section 6011(b)]

The penalty period is when a Medicaid applicant is ineligible for Medicaid payment for long-term care services because the applicant transferred assets for less than fair market value during the look-back period. Before the DRA, the penalty period began either when the transfer was made or on the first day of the following month. The penalty period could expire before the individual needed nursing home care. The DRA changes the start of the penalty period to the date when the individual transferring the assets enters a nursing home and would otherwise be eligible for Medicaid coverage but for the transfer. In other words, the penalty period does not begin until the nursing home resident is out of funds and has no money to pay the nursing home for however long the penalty period lasts. This change could have negative consequences for both nursing homes and residents. Nursing homes will likely be on the hook for the care of residents waiting out extended penalty periods. If nursing homes end up flooded with residents who need care but have no way to pay for it, they will begin looking for alternatives. In states with so-called "*filial responsibility laws*," nursing homes may seek reimbursement from the residents' children. These rarely enforced laws, which are on the books in 30 states, hold adult children responsible for the financial support of indigent parents and, in some cases, medical and nursing home costs. In addition, some states have passed laws providing that if a transfer occurs within 5 years of a Medicaid application, the state can assume the transfer was made to establish Medicaid eligibility and retrieve the value of the Medicaid care services from the person who received the property.

When Period of Ineligibility Starts and the Penalty

If the applicant (or their spouse) has transferred assets for less than fair market value on or after the look-back date, the starting period of ineligibility will be the later of:

- The first day of the month during or after which assets have been transferred for less than fair market value; or
- The date on which the individual is eligible for Medicaid and would otherwise be receiving institutional level of care based on an approved application for such care but the application of the penalty period.

The length of the penalty period is calculated by taking the uncompensated value of the transfer and dividing it by the average private patient cost of nursing facility care in the state at the time of application for Medicaid benefits. The average cost to a private patient of nursing facility care is often referred to as the "*private pay care rate*" or the "*penalty divisor*."

For example, in Florida, the monthly penalty divisor is $10,438/month in 2025. The following is an example of calculating the Medicaid transfer penalty.

> ***For Example:*** On January 1, 2023, Maria made an uncompensated transfer to her children valued at $100,000. Maria had a stroke 20 months later. On July 1, 2025, Maria is now in a nursing home, and her Medicare rehabilitation days have run out. She then applies for Medicaid as she is out of money, having given most of it away some 20 months earlier. Her countable assets now do not exceed $2,000, and her income is below the income cap. Because of the gift of $100,000 in the look-back period, a transfer penalty is calculated as follows: $100,000/$10,438 = 9.6 months (i.e., the amount of the gift divided by the penalty divisor = the penalty period). Thus because of the 2023 transfer, Maria will <u>not</u> be eligible for Medicaid benefits for some 9.6 months from July 1, 2025, the day she was otherwise eligible for Medicaid and has applied for Medicaid in the nursing home.

Note: The transfer penalties don't cause a period of ineligibility for Medicaid-paid home care, but only to nursing and assisted living facilities.

Imposing Partial Months of Ineligibility [Section 6016(a)]

The DRA prohibits states from rounding down or otherwise disregarding any fractional period of ineligibility. Previously, when states calculated the penalty period (value or uncompensated asset/average cost of care in nursing facilities) and the quotient was a fraction, the law allowed them to round down or not include in the ineligibility period the quotient amounts that were less than one month.

> *For Example:* If the average cost of care were $5,000 and the asset was valued at $56,000, the quotient would be 11.2 months of ineligibility. States could round

this down to 11 months. Under the DRA, they must include the additional days in the penalty period.

Hardship Waivers [Section 6011(d)(e)]

The DRA codifies federal guidance on when states may grant waivers of the penalty periods when the penalty will create a hardship on the person transferring the asset (transferor). Specifically, the waiver should be granted if a state finds that the penalty would deprive the individual of medical care to the extent that his health or life would be endangered or deprived of food, clothing, shelter, or other life necessities.

The act requires states to provide for:

- Notice to recipients that an opportunity for a hardship exception exists.
- A timely process for determining whether a waiver will be granted; and
- A process for appealing an adverse determination.

It permits nursing facilities to file the hardship waiver applications on the resident's behalf, with consent. Department of Social Services (DSS) regulations already provide hardship waivers (Uniform Policy Manual, Section 3028.25). But the nursing facilities' authority to request the waivers is new.

If applications for waivers meet established criteria (to be set by the Secretary of HHS), states have the option of providing up to 30 days of payments to nursing facilities to hold the resident's bed while the application is pending. DSS indicates that it does not intend to do this.

Codifying "Income First" Methodology for Protecting Community Spouse

As was discussed earlier, in 1988, Congress changed the Medicaid law to financially protect couples when one spouse entered an institution while the other remained in the community. The "spousal impoverishment" provisions were designed to give the "community" spouse a minimum amount of assets and monthly income with which to maintain herself without having to resort to institutional care herself.

The law exempts all the community spouse's income (e.g., Social Security) from being considered available to the institutionalized spouse for Medicaid eligibility. It also establishes a minimum monthly needs allowance (MMNA) to ensure they have enough resources to meet their monthly living costs.

States must also allocate a portion of a couple's combined assets to the community spouse, the remainder going towards the institutionalized spouse's care costs. To establish the "community spouse protected amount" (CSPA), assets of both spouses are combined and then divided evenly, with the institutionalized spouse's share going directly into paying for the care (before Medicaid will pay). At the same time, the community spouse keeps their share up to a specified limit.

States must attribute income to each spouse according to their ownership interest. Then, the state compares the community spouse's monthly income to the MMNA. If the community spouse's income is less than the MMNA, the institutionalized spouse can transfer an amount of their income or assets to make up for the shortfall.

Changing MMNA. If a community spouse wants to raise her income to the MMNA level, she appeals through a state's fair hearing process. The state can then decide whether to allocate more of the institutionalized spouse's income or assets to them.

States have generally used two different methods when making these decisions. The "income-first" methodology requires that the institutionalized spouse's income first be allocated to the community spouse, with the remainder, if any, going to pay for the institutionalized spouse's care costs.

Unless the transferred income is insufficient to raise the community spouse's income to the agreed-upon level using this method, the assets of the institutionalized spouse (e.g., an annuity or other income-producing asset) cannot be transferred to her to raise her income. This method generally requires the couple to deplete a larger share of their assets. The share the institutionalized spouse retains must be spent on his care before Medicaid pays.

Under the "resource-first" method, the couple's assets are protected first for the community spouse's benefit to the extent necessary to ensure that her total income, including income generated by the CSPA, meets (or exceeds, if allowed) the MMNA. Additional income from the institutionalized spouse that may be, but has not been, made available to the community spouse would be used toward the institutionalized spouse's care costs, making this spouse eligible for Medicaid more quickly.

The Deficit Reduction Act requires states to use the income-first methodology. This change went into effect on February 8, 2006.

Home Equity Limits (Section 6014)

Before the enactment of the DRA, an individual could still qualify for long-term care services even if they had substantial assets in their home. Under the DRA, states will not cover long-term care services for individuals whose home equity exceeds $730,000 in 2025 (up from $713,000 in 2024). However, states have the option of increasing this equity limit to $1,097,000 (up from $1.071,000 in 2024). In all states and under the DRA, the house may be kept with no equity limit if the Medicaid applicant's spouse or another dependent relative lives there .

Disclosure and Treatment of Annuities (Section 6012)

The DRA added requirements for disclosing immediate annuities, which have been useful long-term care planning tools. In its simplest form, an immediate annuity is a contract with an insurance company under which the consumer pays a certain amount of money to

the company. The company sends the consumer a monthly check for the rest of their life or a prescribed time. An immediate annuity can be used to convert assets into an income stream to benefit an institutionalized Medicaid applicant or the applicant's spouse. The state will not treat the annuity as an asset countable toward Medicaid's asset limit ($2,000 in most states plus up to $157,920 estimated for 2025 for the healthy spouse) if the annuity complies with certain requirements. The annuity must be:

- *Irrevocable*–the annuitant cannot take funds out of the annuity except for the monthly payments.
- *Non-transferable*–the annuitant cannot be able to transfer the annuity to another beneficiary; and
- *Actuarially sound*–the payment term cannot be longer than the annuitant's life expectancy. The total of the anticipated payments has to equal the cost of the annuity.

To these requirements, the DRA added a requirement. The state must be named the remainder beneficiary of any annuities up to the amount of Medicaid benefits paid on the nursing home resident's behalf. If the Medicaid recipient is married or has a minor or disabled child, the state must be named a secondary beneficiary. The Medicaid application must also inform the applicant that if they obtain Medicaid benefits, the state automatically becomes a beneficiary of the annuity. In addition, all annuities must be disclosed by an applicant for Medicaid regardless of whether the annuity is irrevocable or treated as a countable asset. If an individual, spouse, or representative refuses to disclose sufficient information related to any annuity, the state must either deny or terminate coverage for long-term care services or else deny or terminate Medicaid eligibility.

State Long-Term Care Partnerships (Section 6021)

Many middle-income people have too many assets to qualify for Medicaid but can't afford a pricey long-term care insurance policy. So-called "partnership" programs, previously available in only four states–California, Connecticut, Indiana, and New York–offer special long-term care policies that allow buyers to protect assets and qualify for Medicaid when the long-term care policy runs out. The DRA allows all states to create such programs to encourage more people to purchase long-term care insurance.

Continuing Care Retirement Communities (Section 6015)

The DRA now expressly allows continuing care retirement communities (CCRCs) to require residents to spend-down their declared resources before applying for Medicaid. However, the spend-down requirements must still consider the income needs of the Medicaid applicant's spouse. The DRA also requires that three conditions be met before a CCRC entrance fee can be considered an available resource for someone applying for Medicaid coverage of nursing home care. The entrance fee must be used to pay for the individual's care; the fee or any remaining portion must be refundable on the institutionalized individual's death or termination of the admission contract when the individual leaves the CCRC. The fee must not grant individual ownership interest in the CCRC.

Promissory Note, Loan, or Mortgage

Funds used to purchase a promissory note, loan, or mortgage during the look-back period will be treated as an exempt transfer only if the note, loan, or mortgage:

- Has an actuarially sound repayment term, as determined following actuarial publications of the Office of the Chief Actuary of the Social Security Administration (in this context, "actuarially sound" means that the term of the note must not exceed the lender's life expectancy).
- Provides for payments to be made in equal amounts during the term of the loan, with no deferral of payments or balloon payments allowed; and
- Prohibits the cancellation of the balance upon the death of the lender.

If a promissory note, loan, or mortgage does not satisfy all three requirements, the value of such note, loan, or mortgage will be the outstanding balance due as of the date of the individual's application for medical assistance.

Life Estate

The DRA also provides that the purchase of a life estate interest in another individual's home will be treated as a transfer of assets unless the purchaser resides in the home for a period of at least one year after the date of the purchase.

Planning Opportunity: At a minimum, in the situation where an elderly parent who will not require skilled nursing home care for the foreseeable future wants to move into a child's home, DRA 2005 will allow the parent to essentially buy a life estate interest in the child's existing home. To avoid any gift treatment, the purchase price for the life estate interest should be based on the parent's life expectancy and a reasonable valuation of the property.

> ***For Example****:* Beatrice, age 75, accepts her daughter Denise's invitation to come and live with her and her family. Denise and her husband own a home that has a fair market value of $100,000. Given Beatrice's age and an assumed rate of 5.8%, her life estate would have a value of $42,477. If Beatrice pays Denise and her husband that amount in exchange for a life estate interest in their home and she lives in the home for at least one year, the $42,477 payment will be treated as an exempt transfer.

Medicaid Expansion and the ACA

The Affordable Care Act (ACA) has resulted in numerous changes to Medicaid and certainly has had and will continue to impact the program's expenditures and enrollment substantially. Unless, of course, the GOP gets to repeal ACA.

States Participating/Not Participating in the Medicaid Expansion

As of May 2025, 41 states (including the District of Columbia) have adopted the Medicaid expansion (see Table 17.5), and 10 states have not adopted the expansion (see Table 17.6). States can decide to implement the Medicaid expansion at any time.

Table 17.5
States Expanding Coverage of their Medicaid Program

Alaska	Illinois	Michigan	New York	Utah
Arizona	Indiana	Minnesota	North Carolina*	Vermont
Arkansas	Idaho	Missouri*	North Dakota	Virginia
California	Iowa	Montana	Ohio	Washington
Colorado	Kentucky	Nebraska	Oklahoma*	West Virginia
Connecticut	Louisiana	Nevada	Oregon	
Delaware	Maine	New Hampshire	Pennsylvania	
D.C.	Maryland	New Jersey	Rhode Island	
Hawaii	Massachusetts	New Mexico	South Dakota	

Note: *The following states have adopted Medicaid expansion but not yet completed expansion: Oklahoma, North Carolina and Missouri. Source: Kaiser Family Foundation; https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

Reminder: Regardless of whether they expand Medicaid or not, all states are required to establish streamlined, coordinated, and automated Medicaid eligibility and enrollment systems to facilitate enrollment in Medicaid and promote continuity of coverage.

Table 17.6
States Not Expanding Coverage of their Medicaid Program

Alabama	South Carolina
Florida	Tennessee
Georgia	Texas
Kansas	Wisconsin
Mississippi	Wyoming

Source: Henry J. Kaiser Family Foundation: Status of State Medicaid Expansion, May 2025
https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

State Medicaid expansion decisions have major implications for low-income non-elderly adults. In the 40 states and the District of Columbia moving forward with the expansion, the median eligibility threshold for parents rose to 138% FPL. By contrast, in the 11 non-expansion states, the median threshold for parents is 49% FPL; in many of these states, the eligibility level is lower than the poverty level, including 9 states where the threshold is lower than 50% FPL. Similarly, the eligibility threshold for childless adults is now

138% FPL in the expansion states. In contrast, these adults remain ineligible for Medicaid in the non-expansion states at any income level, except in Wisconsin, which covers childless adults up to 100% FPL under a waiver. In the states not currently expanding Medicaid, nearly 5 million uninsured non-elderly adults with incomes above the states' limited eligibility levels but below 100% FPL fall into a coverage gap; they cannot qualify for Medicaid because their income exceeds their state's eligibility cutoff, but they do not earn enough to qualify for federal subsidies to purchase coverage through the Marketplaces. These subsidies begin at 100% FPL. An additional 2.8 million adults with incomes between 100% and 138% FPL who would have been eligible for Medicaid under the expansion may be eligible for premium subsidies to purchase coverage through Marketplace.

Who Pays for Medicaid Expansion?

The cost of Medicaid expansion is paid by both the state and federal government, but the federal government pays 90% of the cost (see Table 17.7). The federal government paid the full cost of expansion for the first three years (2014-2016) under the Affordable Care Act. The government's portion gradually dropped to 90% by 2020, and it now stays there permanently (for perspective, under traditional Medicaid –i.e., the non-expansion population—states can pay up to 50% of the cost).

Table 17.7
Federal Medical Assistance Percentage for Newly Eligible*

Year	Federal Government	Each State Pays
2014-2016	100%	0%
2017	95%	5%
2018	94%	6%
2019	93%	7%
2020-2025	90%	10%

* Applies only to states who choose to participate in Medicaid's expansion
*Includes Medicaid eligible who have not applied

For states that expand Medicaid, the federal funding they receive will always dwarf the amount that the state has to spend. And although states have to cover 10% of the cost of Medicaid expansion, their net spending can be much less that – even negative in some cases. There are a few reasons for that:

- Medicaid expansion allows some states to shift certain populations from traditional Medicaid eligibility to the Medicaid expansion category, where the federal government pays a much larger portion of the cost.
- Medicaid expansion reduces the need for state spending on uncompensated care and mental health/substance abuse treatment for low-income residents since fewer low income people in the state are uninsured. It also allows states to use

the Medicaid program to cover the cost of inpatient medical care for incarcerated people.

- The cost of Medicaid expansion can sometimes be offset by increased revenues for the state, including revenue from taxes/fees assessed on hospitals, medical providers, and insurers, increased tax revenues due to economic growth linked to Medicaid expansion, and premiums that a few states require some Medicaid expansion enrollees to pay.

Consolidated Appropriations Act of 2023

On December 29, 2022, President Biden signed into law the Consolidated Appropriations Act, 2023 (p.l. 117-328).1 The Consolidated Appropriations Act ("CAA") includes a number of provisions related to Medicaid and the Children's Health insurance program (CHIP). This includes, among others,

- Delinking the Medicaid continuous coverage requirement from the COVID-19 public health emergency and starting its unwinding after March 31, 2023;
- Requiring all states to provide 12 months of continuous eligibility for children in both Medicaid and CHIP;
- Extending federal funding for CHIP for an additional two years;
- Making permanent a state option to provide 12 months postpartum coverage in Medicaid and CHIP;
- Significantly increasing federal Medicaid funding for Puerto Rico and the other territories over the next five years; and
- Instituting several Medicaid and CHIP improvements related to mental health and juvenile justice.

Another notable provision of the CAA is enhanced funding for home and community-based services (HCBS). With an aging population and a growing demand for long-term care, the CAA's investment in HCBS reflects an emphasis on Medicaid's role in supporting individuals who prefer to receive care in their homes rather than institutional settings. This funding increase is intended to bolster the Medicaid HCBS workforce, improve service delivery, and support states in addressing waiting lists for these services.

Overview of Proposed Medicaid Changes Under OBBBA

The "One Big Beautiful Bill," championed by President Trump and House and Senate Republican leadership, represents one of the most ambitious overhauls of federal entitlement programs in decades. At the center of this legislation effort are deep structural changes to Medicaid, including children, seniors, people with disabilities, and working poor adults. If enacted by its scheduled signing date of July 4, 2025**,** the bill would not only reshape Medicaid's funding structure and eligibility criteria, but also reframe the public debate around healthcare access, personal responsibility, and state control.

Projected Medicaid Spending Reducitons

According to independent analysis of the legislation and estimates by the Congressional Budget Office (CBO) and Kaiser Family Foundation (KFF), the bill proposes to cut approximately $793 billion in federal Medicaid spending over the next decade. These reductions would be achieved through a combination of eligibility restrictions, funding caps, and administrative changes. The CBO estimates that such cuts would result in 7.8 million fewer Medicaid enrollees by 2034. When combined with reductions to Affordable Care Act (ACA) marketplace subsidies and other public insurance mechanisms, the bill could increase the number of uninsured Americans by up to 16 million**.**

Key Policy Changes in the Bill Affecting Medicaid

- **Medicaid Work Requirements.** The bill mandates that able-bodied adults between the ages of 19 and 64 must work, volunteer, or participate in job training for a minimum of 80 hours per month to remain eligible for Medicaid. States would have latitude to impose stricter reporting and compliance requirements. While proponents argue this will promote self-reliance and reduce fraud, empirical studies of work requirement experiments (e.g., in Arkansas) found that thousands lost coverage due to administrative barriers, with no significant gains in employment.
- **Eligibility and Enrollment Restrictions.** The OBBBA would make it harder for individuals to qualify for and maintain Medicaid coverage. Provisions include:
    - More frequent income verifications.
    - Shortened grace periods for missed documentation.
    - Reduced presumptive eligibility programs.
      These changes could lead to significant "churn**"**—people losing coverage temporarily due to procedural errors—even if they remain eligible.
- **Funding Caps and Reduced Federal Match Rates.** Currently, Medicaid is an open-ended entitlement: the federal government matches state spending without a set limit. Under OBBBA, states would receive capped federal block grants or per capita allotments, indexed to general inflation (not medical inflation). This would shift more financial risk to states, especially during economic downturns, public health emergencies, or periods of demographic change.
- **Coverage Exclusions and Provider Restrictions.** Medicaid funds would be prohibited from covering gender-affirming care or abortion services—even in states that currently allow them.
    - Federal funding would also be limited for providers who offer these services, which could result in clinic closures or service cutbacks in underserved communities.

Consequences for Beneficiaries.

The most immediate and measurable impact would be the reduction in total Medicaid enrollment. In addition to the 7.8 million projected to lose eligibility due to budget cuts and work requirements, analysts estimate up to 12 million Americans could lose Medicaid coverage by 2034 when all program changes are accounted for.

Populations likely to be most affected include:

- Low-income adults in expansion states
- Older adults under age 65 with chronic illnesses
- People with disabilities who fail to meet work documentation rules
- Rural residents, particularly in states with limited provider networks

Multiple studies link Medicaid coverage with better access to preventive care, lower mortality rates, and reduced medical debt. The proposed reductions in coverage are expected to lead to worsened health outcomes, delayed diagnoses, and increased avoidable deaths. According to a 2025 Guardian report, health policy experts warn that "thousands of Americans are likely to die" as a result of lost coverage.

Impact on Providers and State Budgets

Rural hospitals and community health centers—many of which rely on Medicaid as a primary payer—would be severely affected. According to the American Hospital Association, rural providers could face $50 billion in federal funding losses over the next 10 years, threatening the viability of many critical access hospitals.

States will face higher administrative costs to enforce work requirements, manage compliance tracking, and implement the new eligibility criteria. These burdens may divert funding away from care delivery and further strain state budgets.

With fewer covered individuals, emergency rooms may once again become a de facto safety net. The reduction in preventive and primary care access could increase uncompensated care costs for hospitals and shift costs back onto private insurance payers through higher premiums.

Policy and Political Implications

Supporters' Arguments:

- Supporters of the bill argue that it will:
- Rein in unsustainable entitlement growth.
- Encourage personal responsibility.
- Give states greater flexibility to tailor programs.

Critics' Concerns

Opponents view the bill as a regressive rollback of the social safety net, arguing that:
There is little evidence that work requirements lead to long-term employment.
Vulnerable Americans will bear the brunt of the cuts.
The bill shifts the nation further away from a commitment to healthcare access.

Health policy organizations, hospital groups, disability advocates, and even some state Medicaid directors have publicly opposed the bill, citing serious concerns about its feasibility and humanitarian consequences.

Conclusion

If passed, the One Big Beautiful Bill would represent the most consequential reshaping of Medicaid since its creation in 1965. Its effects would ripple across every aspect of healthcare delivery for low-income Americans—reducing enrollment, restricting coverage, burdening providers, and destabilizing safety-net institutions. While advocates frame the bill as a return to fiscal conservatism and state control, its critics warn of grave public health consequences, especially for the nation's most vulnerable populations.

The next several months will be pivotal in determining whether this legislation becomes law—and if so, whether the nation is prepared for the profound transformation it would bring to the Medicaid landscape. Stay Tuned!

Further Reading

Federal Medicare Assistance Percentage (FMAP) for Medicaid Multiplier
https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B"colId":"Location","sort":"asc"%7D

Federal Register Vol 88 FMAP; November 21, 2023
https://www.govinfo.gov/content/pkg/FR-2023-11-21/pdf/2023-25636.pdf

Kaiser Family Foundation, "*Medicaid Enrollment & Spending Growth: FY 2024 & 2025*;" Medicaid Enrollment & Spending Growth: FY 2024 & 2025 | KFF

Medicaid Enrollment and Unwinding Tracker, Published October 9, 2024
Medicaid Enrollment and Unwinding Tracker | KFF

Kaiser Family Foundation, Medicaid 101, Published May 28, 2024
What Is Medicaid? - Medicaid 101 | KFF

Kaiser Family Foundation; Status of State Action on Medicaid Expansion, May 8, 2024
Status of State Medicaid Expansion Decisions: Interactive Map | KFF

Congressional Budget Office, "Medicaid's Federal Medical Assistance Percentage (FMAP), Updated July 29, 2020": https://crsreports.congress.gov/product/pdf/R/R43847

Federal Funds Information For States; Final FY 2022 FMAPS, released September 20, 2021; https://ffis.org/PUBS/issue-brief/20/23

CMS; National Health Care Expenditure Fact Sheet (2023); NHE Fact Sheet | CMS

CMS, June 2024 Medicaid and CHIP Enrollment
June 2024 Medicaid & CHIP Enrollment Data Highlights | Medicaid

Elder Law Answers; "*Spending down Assets to Qualify for Medicaid*;
https://www.elderlawanswers.com/spending-down-assets-to-qualify-for-medicaid-12003

Kaiser Family Foundation, Health Provisions in the 2025 Federal Budget Reconciliation Bill, June 30, 2025
https://www.kff.org/tracking-the-medicaid-provisions-in-the-2025-budget-bill/

Revised Draft of the Senate's reconciliation bill
https://www.budget.senate.gov/imo/media/doc/the_one_big_beautiful_bill_act.pdf

Chapter 17
Review Questions

1. In 1960, which Act created a new program called "Medical Assistance for the Aged?"

( ) A. Kerr- Mills Act
( ) B. Deficit Reduction Act
( ) C. Social Security Act
( ) D. Employee Retirement Income Security Act

2. For FY 2025, what is the maximum monthly maintenance needs allowance (MMMNA)?

( ) A. $967
( ) B. $3,948
( ) C. $2901
( ) D. $1,450

3. For FY 2025, CMS increased the maximum community spouse resource allowance (CSRA) to what amount?

( ) A. $3,000
( ) B. $713,000
( ) C. $157,920
( ) D. $2,000

4. The DRA of 2005 extended the "*look back period*" to how many months?

( ) A. 6 months
( ) B. 24 months
( ) C. 36 Months
( ) D. 60 months

5. Which of the following states was not one of the so-called "partnership" programs?

( ) A. Connecticut
( ) B. Florida
( ) C. New York
( ) D. California

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CHAPTER 18

MEDICAID PLANNING

Overview

The term Medicaid planning encompasses a wide variety of services provided by an equally wide variety of professionals. A general definition of Medicaid planning is any assistance provided to a potential Medicaid applicant in advance of, and in preparation for their Medicaid application. Medicaid planning can be as simple as assistance with collecting and preparing documents or as complicated as a complete restructuring of a client's financial assets.

This chapter will examine some of the Medicaid planning options available to applicants/residents of long-term care facilities that can be used to become eligible for Medicaid Planning. Much of the complexity associated with Medicaid planning occurs when an individual 's monthly income or resources are near or above the financial eligibility limits. We will examine the issue of transferring assets, the use of trusts, annuities, and promissory notes. But first, we will discuss the ethical and moral position of providing Medicaid Planning advice to your clients.

Learning Objectives

Upon completion of this chapter, you will be able to:

- Recognize the ethical and moral implications of Medicaid planning.
- Apply the rules concerning transferring assets in the "crisis" period.
- List the various types of trusts used in Medicaid planning.
- Utilize a Medicaid Annuity to convert a resource into an income source.
- Offer the benefits of purchasing an annuity inside an IRA; Structure planning with promissory notes.
- Present the Medicaid Estate Recovery Program; and
- Determine the role of children in paying for their parents' LTC.

The Ethics of Medicaid Planning

Many years ago, I would conduct seminars on Medicaid Planning with the objective to educate attendees on how legally they could reposition and/or convert assets as needed to allow them to qualify for Medicaid financially. After every seminar, I would always have someone comment that what I was doing was morally and ethically wrong. Was it?

At the same time, I was also conducting several Estate Planning seminars where I would educate clients on the legal ways to lower their estates while, in return, lowering their federal estate taxes. Would you say that Estate Planning is morally and ethically wrong?

The common objections to Medicaid Planning are usually stated as:

- Medicaid is for the "poor," not for people who have money and can hire the lawyers to shelter their assets.
- If left unchecked, Medicaid planning will bankrupt the system.
- The result of unchecked Medicaid planning will be a two-tiered system of long-term care: those who can pay privately for good care and those with no money who are forced into Medicaid nursing homes that provide substandard care; and
- Medicaid planning is a form of elder abuse. Because many elders in nursing homes lack the mental capacity to choose to do Medicaid Planning, their children–who stand to gain most from saving the money from the nursing home–make a choice for them. Instead of the elder's assets being expended to pay for good long-term care, the assets wind up in the children's hands–and the elder winds up with substandard long-term care.

Whatever the objections may be, it is important to remember that Medicaid is a government program. Through our tax dollars, we have financially supported all aspects of our government throughout our earning years. Why then should the infirmity of old age and ill-health allow that government to strip us of our life's efforts, dignity, and self-esteem?

If the government has set up several Medicaid fairness exceptions (discussed below) that we can use advantageously in our own Medicaid planning, then why do we not have the right to understand those exceptions and decide in what we can do legally vs. illegally in order to qualify for Medicaid?

As an advisor, it is your ethical responsibility to understand the Medicaid rules and the fairness exceptions provided by the government so you can help your clients plan and cope with the devastating effects, both psychological and financial, if necessary, yet expensive, long-term nursing home care. It is the knowledge of how to appropriately use these government-approved fairness exceptions that an Elder Law attorney employs to help those who are not super-rich stop the hemorrhaging of their resources.

It is my own belief that it is both ethical and honorable to help moderate the financial and psychological devastation that can accompany the need for long-term care by those who, through no fault of their own, need such care.

Transferring Assets to Qualify for Medicaid

Did you know that transferring assets to achieve Medicaid eligibility is a crime? To be sure, for a brief period, it was, and it is possible that it could be in the future. In 1993, The Omnibus Budget Reconciliation Act (OBRA) was passed and required states to

recover all property and assets that pass from a deceased person to their heirs under state probate law, which includes property passed by will and property of persons who die intestate (without a will). In 1996, the United States Congress passed the Kennedy-Katzenbaum health care bill, named after Senators Ted Kennedy (MA) and Nancy Katzenbaum (KS). The bill made it a crime to transfer assets to become eligible for Medicaid assistance. As a point of reference: In 1997, Congress repealed the law but made it a crime to advise or counsel someone for a fee regarding transferring assets for purposes of obtaining Medicaid. In 1998, Attorney General Janet Reno determined that the law was unconstitutional and told Congress that the Justice Department would not enforce the law. However, the states are permitted to recover Medicaid costs (discussed below) and can expand the definition of an estate beyond that subject to probate.

Now that you have some background on the law, let's examine the planning issues with transferring assets to qualify for Medicaid. As was discussed in the previous chapter, Congress has established a period of ineligibility for Medicaid for those who transfer assets. For transfers made prior to February 8, 2006, state Medicaid officials would look only at transfers made within the 36 months prior to the Medicaid application (or 60 months if the transfer were made to or from certain kinds of trusts). For transfers made after February 8, 2006, the so-called "*look-back*" period for all transfers is 60 months. While the look-back period determines what transfers will be penalties, the length of the penalty depends on the amount transferred. The penalty period is determined by dividing the amount transferred by the state's average monthly cost of nursing home care.

As the advisor, it is important to discuss with your clients that any transfers should be made carefully, understanding all the consequences. You should also recommend that anyone who makes transfers should not apply for Medicaid before the five-year look-back period elapses without first consulting with an Elder Law attorney. This is because the penalty could ultimately extend even longer than five years, depending on the size of the transfer.

One of the prime planning techniques used before the enactment of the Deficit Reduction Act of 2005 (DRA), often referred to as "half a loaf," was for the Medicaid applicant to give away approximately half of their assets. It worked this way: Before applying for Medicaid, the prospective applicant would transfer half of their resources, thus creating a Medicaid penalty period. The applicant, who was often already in a nursing home, then used the other half of their resources to pay for care while waiting out the ensuing penalty period or had purchased an LTC insurance contract to cover the costs during that period. After the penalty period had expired, the individual could legally apply for Medicaid coverage.

> ***For Example****:* Mrs. Thomas had savings of $72,000. The average private-pay nursing home rate in her state is $6,000 a month. When she entered a nursing home, she transferred $36,000 of her savings to her son. This created a six-month period of Medicaid ineligibility ($36,000/$6,000=6). During these six months, she used the remaining $36,000 plus her income to pay privately for her nursing home care. After the six-month Medicaid penalty period had elapsed, Mrs.

Thomas would have spent down her remaining assets and be able to qualify for Medicaid coverage.

One of the main goals of the DRA was to eliminate this kind of planning. To determine whether it is still an available strategy in your state, you should consult with a local Elder Law attorney.

Reminder: Any transfer strategy must consider the nursing home resident's income and all of their expenses, including the cost of the nursing home. Bear in mind that if the applicant gives money to their children, it belongs to them, and the applicant should not rely on them to hold the money for their benefit. However well-intentioned they may be, the children could lose funds due to bankruptcy, divorce, or lawsuit**.**

Transfers can also have bad tax consequences for the children. This is especially true of assets that have appreciated, such as real estate and stocks. If one gives these to their children, they will not get the tax advantages they would get if they were to receive them through the estate. The result is that when the children sell the property, they will have to pay a much higher tax on capital gains than they would have if they had inherited it (and received the stepped-up basis at death).

Permitted Transfers

While most transfers are penalized with a period of Medicaid ineligibility of up to 60 months, certain transfers are exempt from this penalty. Even after entering a nursing home, the applicant/resident may transfer any asset to the following individuals without having to wait out a period of Medicaid ineligibility:

- Applicant's/resident's spouse (but this may not help eligibility since the same limit on both spouse's assets will apply).
- Applicant's/resident's child who is blind or permanently disabled.
- Into trust for the sole benefit of anyone under age 65 and permanently disabled.
- In addition, the applicant/resident may transfer their home to the following individuals (as well as to those listed above):
    - Child who is under age 21.
    - Child who has lived in the home for at least two years prior to applicant/resident moving to a nursing home and who provided the applicant/resident with the care that allowed them to stay at home during that time; and
    - A sibling who already has an equity interest in the house and who lived there for at least a year before the applicant moved to a nursing home.

Note: Even though a nursing home resident may receive Medicaid while owning a home, if the applicant/resident is married, they should transfer the home to the community spouse (assuming the nursing home resident is both willing and competent). This gives the community spouse control over the asset and allows them to sell it after the nursing home spouse becomes eligible for Medicaid. In addition, the community spouse

should change their will to bypass the nursing home spouse. Otherwise, at the community spouse's death, the home and other assets of the community spouse will go to the nursing home spouse and have to be spent down.

Medicaid Planning and Trusts

As was discussed above, the problem with transferring assets is that assets no longer belong to the applicant, they no longer control them, and even a trusted child or another relative may lose them. A safer approach is to put them in a trust.

A trust is a legal entity under which one person–the "trustee"–holds legal title to property for the benefit of others–the "beneficiaries." The trustee must follow the rules provided in the trust instrument. Whether trust assets are counted against Medicaid's resource limits depends on the terms of the trust and who created it.

Medicaid rules significantly restrict transfers of assets to and from certain lifetime trusts (revocable and irrevocable trusts) where the assets of the Medicaid applicant are used to form all or a part of the trust principal.

Note: Except in limited circumstances, the following rules do not apply to trusts created and funded by persons other than the Medicaid applicant (known as Third Party Trusts), even if the applicant is a beneficiary of the trust.

Revocable Trusts

A "Revocable" trust is one that may be changed or rescinded by the person who created it. Medicaid considers the principal of such trusts (that is, the funds that make up the trust) to be countable assets in determining Medicaid eligibility.

There will be no transfer penalty imposed in transfers to a Revocable trust created by the applicant. They have reserved a right of revocation because the trust assets will continue to be considered an available resource. Any payment to or for the benefit of the applicant will be considered countable income. However, transfers from a revocable trust to a person other than the applicant will be treated as a transfer for less than fair market value and trigger the look-back period.

Bottom line: A revocable trust is of no use in Medicaid planning.

Irrevocable Trust

An "irrevocable" trust cannot be changed after it has been created. In most cases, this type of trust is drafted to make the income payable to the person establishing the trust, called the "grantor," for life. The principal cannot be applied to benefit the applicant or their spouse.

At the applicant's death, the principal is paid to their heirs. This way, the funds in the trust are protected, and the applicant can use the income for their living expenses. For Medicaid purposes, the principal in such trusts is not counted as a resource, provided the trustee cannot pay it to the applicant or their spouse for either of their benefits. However, if the applicant enters a nursing home, the trust income will go to the nursing home.

As the advisor, you should be aware of the drawbacks of such an arrangement. It is very rigid, so the applicant cannot access the trust funds even if they need them for some other purpose. For this reason, the applicant should always leave an ample cushion of ready funds outside the trust.

You may also choose to place the property in a trust from which even income payments to the applicant or their spouse cannot be made. Instead, the trust may be set up to benefit the applicant's children or others. These beneficiaries may, at their discretion, return the favor by using the property for the applicant's benefit if necessary. However, there is no legal requirement that they do so.

One advantage of the irrevocable trust is that if it contains property that has increased in value, such as real estate or stock, the grantor (applicant) can retain a "special testamentary power of appointment" so that the beneficiaries receive the property with a step-up in basis at the grantor's death. This will also prevent the need to file a gift tax return upon the funding of the trust.

Remember, funding an irrevocable trust can cause the applicant/resident to be ineligible for Medicaid for the following five years.

The look-back rules will apply to transfers to an irrevocable trust if the trust instrument provides that there is any portion of the principal or income from which no payment can be made to the grantor under any circumstances. In this case, the date of the transfer is deemed to be the date of establishing the trust or, if later, the date on which payment to the individual was foreclosed.

If there are any circumstances under which payment of principal or income can be made from an irrevocable trust to or for the benefit of the applicant, then such principal or income will be considered an available resource, and payments to or for the benefit of the individual will be treated as income. Under these rules, it does not matter what degree of discretion is given to the trustee. No matter how restrictively the discretionary standards may be defined, the presence of any standards for the benefit of the applicant will result in the trust assets being treated as an available resource. This means that the trust property will remain a countable resource even after the look-back period has expired.
Payments made from the trust "for any other purpose," such as distributions to beneficiaries other than the grantor, will be considered a transfer for less than fair market value and trigger a 60-month look-back period.

There are limited exceptions to these trust transfer rules. The rules will not apply to certain trusts, including the following:

- Special Needs Trusts; and
- Qualified Income Trusts (aka Miller Trusts).

Special Needs Trusts

Special Needs Trusts, also referred to as Special Treatment Trusts or Special Purpose Trusts, are designed to hold assets that can be used to benefit someone who is receiving Medicaid benefits for either a nursing home or other long-term care. These types of trusts prevent the Medicaid beneficiary from being disqualified from Medicaid long-term care for not meeting the financial tests, both assets (resources) and income.

The assets in the special needs trust can provide certain amenities to the disabled beneficiary, so these trusts are sometimes called "supplemental needs" trusts. Special purpose trusts are explicitly designed by state and federal statutes so that the beneficiary won't be disqualified or penalized by transferring assets into the trusts, so long as the requirements for establishing and using the trusts are strictly followed.

Next, let's examine the various types of special needs trusts.

- *First-Party Special Needs Trusts.* If a Medicaid applicant or beneficiary has resources (assets) more than the allowable limit, the applicant/beneficiary can transfer those excess resources to a special needs trust. Since this is a special-purpose trust established by federal law, the applicant is not penalized for transferring assets to this trust (that is, the applicant is not disqualified from Medicaid) if the trust is properly established. A first-party trust consists of the beneficiary's assets. This trust is sometimes referred to as a "*self-settled trust*" or a "*d4a trust*," which refers to the subsection of the federal law that established it [42 USC 1396p(d)(4)(a)]. When someone is already receiving Medicaid, a first-party trust is often used to manage a significant amount of funds received from an inheritance or court settlement. To qualify for a first-party trust, the following requirements must be met:

  The beneficiary must be under the age of 65 and disabled.

  - Trust must be created by a parent, grandparent, guardian, or a court.
  - The state paying out benefits must be designated as the primary beneficiary of the trust; and
  - The assets in the trust may be used only for the benefit of the Medicaid beneficiary.

  Each state has specific guidelines for the use of resources in a first-party special needs trust. Most states require prior approval of expenditures from a special needs trust. Some require that an annual budget be established. Failure to follow state rules will disqualify trust and disqualify the beneficiary from Medicaid. Only resources (assets) can be placed in a special needs trust. A Medicaid beneficiary's income can be placed only in an income trust for Medicaid qualification purposes (also called a Miller Trust or Qualifying Income Trust) discussed below. (But keep in mind that once income has been received, it

becomes a resource the following month. The month after receipt, the month-old income can be placed in the first-party trust);

- *Pooled Trusts.* A pooled trust, also known as a "(d)(4)(C) trust," is a special needs trust with a twist. This trust, operated by a nonprofit organization, pools together the resources of many Medicaid beneficiaries, using what is called a "*master trust*" along with separate "sub trusts," or "subaccounts," for each participating beneficiary. The advantage of this trust is that it does not have the same requirements as a first-party special needs trust and can be created by a Medicaid beneficiary (or applicant) regardless of age (meaning those over 65 can participate in a pooled trust). A Medicaid applicant/beneficiary or their parent, grandparent, guardian, or court can establish a sub-account in a pooled trust. Because a pooled trust accepts contributions from many beneficiaries, the trust can make more stable investments and provide additional management services that a plain vanilla special needs trust might not afford. On top of these benefits, transfers into a pooled trust, like transfers into a first-party special needs trust, do not prevent a person with special needs from accessing government benefits. Upon the death of the Medicaid beneficiary, the state is entitled to reimbursement from the pooled trust for expenses paid on the beneficiary's behalf. Any remaining amount is divided between the charitable organization that created the pooled trust and those designated by the Medicaid beneficiary.
- *Third-Party Special Needs Trusts.* Unlike the first-party special needs trust, which is created only with the Medicaid beneficiary's assets, a third-party special needs trust is created with family members' assets or other relatives or friends. While a third-party trust is sometimes referred to as a special treatment trust, it is not designated in federal law. In fact, this type of special needs trust is not created by statute and has none of the statutory requirements found with first-party trusts. Since these trusts do not contain assets transferred by the beneficiary, but only assets belonging to someone else, the only requirement is that the distribution of trust assets be in the sole discretion of the trustee and that the trust does not allow the beneficiary to demand any type of distribution. The beneficiary never owns the property in the trust and does not have direct access to trust funds. The beneficiary cannot receive cash from the trust. All distributions from the trust must be monitored to ensure that the beneficiary does not become ineligible due to the distribution (for instance, by owning countable assets over the resource limit).

While the state is the primary beneficiary of a first-party special needs trust, any beneficiary can be established with a third-party special needs trust. The state has no right of reimbursement from this trust after the Medicaid beneficiary's death.

Note: None of the trusts discussed above are "Medicaid qualifying trusts" (MQT). Medicaid qualifying trusts are trusts established before 1993 that generally cause the beneficiary to be ineligible for Medicaid.

Qualified Income ('Miller") Trusts

In 1993, the federal government recognized the hardship created in income-cap states when a person with few assets received monthly income just over the cap. In income-cap states only, therefore, applicants may (under certain conditions) establish Miller Trusts, also called Qualified Income Trusts to provide a way for Medicaid applicants who have income over Medicaid's limits to become eligible for Medicaid long-term care services. In short, income over Medicaid's limit is put into a trust and therefore not counted as income, thus allowing the applicant to become eligible.

Miller Trusts are also called by a variety of names. They include the following: Qualified Income Trusts, QITs, Income Diversion Trusts, Income Cap Trusts, Irrevocable Income Trusts, Income Trusts, d4B Trusts, and Income Only Trusts. Regardless of the state's name, the terminology refers to the same type of trust: Qualified Income Trusts.

For income cap states (see Table 18.1), the income limit for nursing home Medicaid and Home and Community Based Services (HCBS) Medicaid Waivers is generally 300% of the Federal Benefit Rate of $967 in 2025 (up from $943 in 2024). Effective January 1, 2025, this equals $2,901/month ($967 x 3), for an individual, and married couple (with both spouses as applicants) will be limited to $5,802/month.. A portion, or all of one's income, can be directly deposited into a Miller trust, and it is not counted towards Medicaid's income limit. Therefore, this option allows an applicant to become income eligible.

Table 18.1
States Allow Miller Trusts/QITs

Alabama	Delaware	Iowa	New Jersey	South Carolina
Alaska	Florida	Kentucky	New Mexico	South Dakota
Arizona	Georgia	Mississippi	Ohio	Tennessee
Arkansas	Idaho	Missouri	Oklahoma	Texas
Colorado	Indiana	Nevada	Oregon	Wyoming

A bank account must be set up and a trust document drawn up to establish a Miller Trust. The person setting up the Income Diversion Trust (the grantor, also called a settlor) can be the Medicaid applicant or their guardian or power of attorney. A trustee, who manages the trust and follows the guidelines set forth by the trust, must be named. This person must be someone other than the Medicaid applicant but can be a relative, such as an adult child. The state in which the Medicaid recipient will receive long-term care benefits must be named the beneficiary. Upon the death of the individual, the state will receive up to an equal amount for which it paid for that individual's long-term care. Trust must be irrevocable, which means the trust cannot be altered or canceled.

Monthly deposits, consisting only of the Medicaid recipient's income, are made (some states require direct deposit, while others do not) into the trust. Some states require all of one's income to be deposited. In contrast, other states permit one to deposit only a portion of their income into the trust. That said, in all states, the entire payment from a

single source must be deposited. For example, if a Medicaid recipient receives only a social security check, the full check must be deposited into the trust. However, if one lives in a state that doesn't require all income to be deposited into the trust and receives both a social security check and a pension check, only one check needs to be deposited. The retained income is not over Medicaid's income limit. Remember, any amount of income deposited into the QIT does not count towards the income limit. In other words, it is exempt.

Note: QITs do not assist persons who are over the Medicaid asset limit in meeting that limit. To be clear, assets cannot be deposited into QITs.

Funds deposited in a Miller/Qualifying Income Trust can only be used for specific purposes. A trustee manages the trust account, which includes paying out money deposited in the trust. If all a Medicaid recipient's income is deposited into the QIT, they can be paid a personal needs allowance (PNA). This amount varies by state and by setting in which the long-term care recipient resides.

In addition to the PNA, if a Medicaid recipient is married and their non-applicant spouse (also called the community spouse, healthy spouse, or well spouse) has little to no income, a monthly maintenance needs allowance can be paid to that spouse. This spousal allowance is intended to prevent the community spouse from the inability to support themself. While this figure varies by state and by circumstances, in most cases, the maximum payout is $3,948/month in 2025 (up from $3,853.50 in 2024)..

Money in Miller Trusts also goes towards paying a "share of cost," or in other words, goes towards paying for the cost of long-term care of the Medicaid recipient. For instance, a payment may go to the nursing home to supplement care costs. In addition, medical bills not paid for by Medicaid, and Medicare premiums, are eligible expenses to be paid from an Irrevocable Income Trust.

The trustee is required to file an annual accounting to the state's Medicaid administrator. The accounting will show all income deposited into the trust account, the checks written, and the account's remaining balance. The trustee should save all bank statements for this purpose. The trustee holds the remaining balance of the trust account until the grantor dies.

Upon the death of the grantor, the trustee must notify the state's Medicaid administrator, who should then inform the trustee of the amount of Medicaid benefits the state had paid for the grantor's care during their lifetime. The trustee then must pay the remaining balance to the state as part payment for the nursing home expenses that Medicaid paid. Upon the death, the trustee cannot spend any money from the trust without permission.

Note: If your client is considering setting up this type of trust, you should certainly have them seek the professional assistance of an Elder Law Attorney knowledgeable in their state's law.

Testamentary Trusts

Testamentary trusts are trusts created under a will. The Medicaid rules provide a special "safe harbor" for testamentary trusts created by a deceased spouse for the benefit of a surviving spouse. The assets of these trusts are treated as available to the Medicaid applicant only to the extent that the trustee has an obligation to pay for the applicant's support. If payments are solely at the trustee's discretion, they are considered unavailable.

Therefore, these testamentary trusts can provide an important mechanism for community spouses to leave funds for their surviving institutionalized husband or wife that can be used to pay for services that Medicaid does not cover. These may include extra therapy, special equipment, evaluation by medical specialists, legal fees, visits by family members, or transfers to another nursing home if necessary. But remember that if the applicant creates trust for themselves or their spouse during life (i.e., not a testamentary trust), the trust funds are considered available if the trustee can use them for the applicant and their spouse.

Medicaid Planning and Annuities

The Deficit Reduction Act (DRA) of 2005 did not eliminate the use of annuities in Medicaid planning. As many rulings and court opinions have stated, if Congress wanted to eliminate the use of annuities in Medicaid planning, it could do so at any time. The DRA only refined the use of annuities by putting in further stipulations that must be met for an annuity to be a non-available resource.

How Purchasing an Annuity Depletes Assets

Purchasing an annuity converts an asset into a stream of monthly income for the community spouse. The community spouse's income is not counted toward Medicaid eligibility. When an asset is turned into community spouse income, the asset “disappears” and no longer interferes with Medicaid eligibility. Purchasing an annuity means the assets don't have to be "spent down" on other things.

To be acceptable to Medicaid, the annuity payments must be completed before the end of the community spouse's life expectancy. This rule prevents the annuity purchase from becoming a gift to heirs (since no money would be left for heirs at the anticipated end of the community spouse's life). If the money is all returned to the community spouse during their lifetime, they will not be able to give the money away for less than what they invested.

Single Premium Immediate Annuity

The type of annuity used for Medicaid transfers is known as a single-premium immediate annuity (SPIA) because it is paid for in a lump sum premium payment and immediately begins paying back the premium to the owner (called the "annuitant"). This is different

from an annuity used for investment purposes that accumulates over a period before it is paid back to the owner, like an IRA.

Immediate annuities can be ideal Medicaid planning tools for spouses of nursing home residents. For single individuals, they are usually less useful. In its simplest form, an immediate annuity is a contract with an insurance company under which the consumer pays a certain amount of money to the company. The company sends the consumer a monthly check for the rest of their life, usually beginning 30 days after purchase.

In most states, the purchase of an annuity is not considered to be a transfer for purposes of eligibility for Medicaid. Still, it is instead the purchase of an investment. It transforms otherwise countable assets into a non-countable income stream. If the income is in the name of the community spouse, it's not a problem.

Let's suppose you have a couple as clients who have $100,000 over the accepted Medicaid resource limit and the desire to keep this $100,000 to benefit the community spouse rather than spending it down. Here's how an annuity can help. The $100,000 is moved to the name of the community spouse. No problem so far because the assets are still countable regardless of which spouse owns the assets. The spouse applying for Medicaid is allowed to transfer unlimited assets to the community spouse.

Next, the community spouse purchases a single-premium immediate annuity from a commercial insurance company. The community spouse owns this annuity. Since it is an immediate annuity, the insurance company is contractually obligated to begin making a series of substantially equal monthly payments to the community spouse.

Why Annuities Don't Violate Medicaid Rules

After an asset (money) is turned into an income stream payable to the community spouse, the applicant qualifies financially for Medicaid. Since the money (in the above example, $100,000) is spent on something of equal value, it's not a gift that affects the Medicaid applicant's eligibility (as the annuity pays back the purchase price over a period less than the life expectancy of the community spouse, eventually paying back the entire $100,000).

Even though the community spouse receives a monthly check that could accumulate into an asset if saved, this never jeopardizes the applicant's future eligibility because once qualified. The Medicaid beneficiary must only show that they don't have over $2,000 in assets. The value of the assets in the community spouse's name is no longer a concern of Medicaid.

Annuity Requirements to Avoid Medicaid Penalties

These requirements must be met to make a community spouse annuity work for a Medicaid applicant:

- The annuity must be purchased from a commercial insurance company.

- The annuity must be immediate.
- The annuity must be irrevocable (you can't cancel it);
- The annuity must be non-assignable and nontransferable (it can't be given to someone else).
- The annuity must pay out in a series of substantially equal monthly payments.
- The term of monthly payments must be less than the life expectancy of the community spouse, according to Social Security life expectancy tables; and
- The Medicaid agency for the state that the Medicaid applicant lives in must be designated as the primary beneficiary of the annuity after the death of the community spouse. This allows the Medicaid agency to collect any unpaid funds should the community spouse die before their life expectancy.

Recent Court Cases

Recent state court cases from 2022 to 2024 that have addressed whether Medicaid compliant annuities should be considered available assets or treated as penalty causing transfers. Below are notable cases, including court reasoning and outcomes.

1. **Dermody v. Massachusetts Executive Office of Health and Human Services (2023)**

   - **Court**: Supreme Judicial Court of Massachusetts
   - **Date**: January 27, 2023
   - **Summary**: Robert Hamel purchased an annuity to help his wife qualify for Medicaid, naming the state as the primary beneficiary and his daughter, Laurie Dermody, as the remainder beneficiary. After Hamel's death, Dermody claimed entitlement to the annuity's remainder.
   - **Court's Reasoning**: The court held that under the Deficit Reduction Act (DRA), when an annuity is used to qualify for Medicaid, the state must be the primary remainder beneficiary to recoup expenses paid on behalf of the Medicaid recipient. Allowing the daughter to receive the remainder would contravene the DRA's intent to prevent asset sheltering.
   - **Outcome**: The court ruled in favor of the state, entitling it to the annuity's remainder to reimburse Medicaid expenses.

   You can read the court's opinion at:
   https://attorney.elderlawanswers.com/scotus-denies-petition-for-cert-in-medicaid-annuity-case-20560

2. **C.L. v. Division of Medical Assistance and Health Services (2022)**

   - **Court**: Appellate Division of the Superior Court of New Jersey
   - **Date**: October 17, 2022
   - **Summary**: The applicant purchased an irrevocable, non-assignable annuity as part of a Medicaid spend-down strategy. The county Medicaid agency denied eligibility, treating the annuity's purchase price as a countable resource.

- **Court's Reasoning**: The court found that the annuity was irrevocable and non-assignable, with no cash value, and provided fixed monthly payments. Therefore, it did not constitute a countable resource under Medicaid regulations, which define a resource as something the owner can convert to cash for support and maintenance.
- **Outcome**: The denial of Medicaid eligibility was reversed, recognizing the annuity as a non-countable asset.

You can read the court's opinion at:
https://finkrosnerershow-levenberg.com/wp-content/uploads/2022/10/C.L.-vs-DMAHS-and-Bergen-Cnty-A-4284-19-Appellate-Decision-10-17-2022.pdf

3. EOHHS v. Mondor (2023)

- **Court**: Supreme Judicial Court of Massachusetts
- **Date**: January 27, 2023
- **Summary**: The case addressed whether the state could claim the remainder of an annuity purchased by a community spouse if the spouse died before the annuity's term ended.
- **Court's Reasoning**: The court held that the state is entitled to the remainder of the annuity upon the community spouse's death, as the annuity was used to qualify the institutionalized spouse for Medicaid. This aligns with federal requirements ensuring states can recoup Medicaid expenses from such annuities.
- **Outcome**: The state was entitled to the annuity's remainder to reimburse Medicaid expenditures.

You can read the court's opinion at:
https://www.krausefinancial.com/wp-content/uploads/2023/08/Dermody-2023.pdf

These cases highlight the judiciary's role in interpreting Medicaid regulations concerning annuities, emphasizing compliance with federal laws designed to prevent asset sheltering while ensuring Medicaid's integrity.

It is important to remember that the states agree to run Medicaid in a "no more restrictive" way than the federal laws governing Medicaid. Even still, they try to go beyond their federal mandate to add little restrictions that they just hope everyone will follow without question. The average Medicaid applicant has neither the time, patience, nor the resources to force the state to comply with their federal mandate.

The federal law–especially after implementing the Deficit Reduction Act (DRA)–is specific about what kind of annuity counts as an income or an asset and when they create a transfer penalty. The federal law puts no restriction on when a Medicaid compliant annuity can be purchased. Medicaid compliant annuities are often purchased in crisis planning cases to convert excess assets into an income stream for the community spouse. This helps the community spouse to keep from going broke and to provide resources for the community spouse's own care and well-being later down the road. This is mostly

done after the snapshot date–a date based upon when the patient entered the hospital or the nursing home, used to determine the total amount that must be spent down.

While not completely specified, the ability to transfer funds into these Medicaid compliant SPIAs is assumed to be allowable after the patient enters the nursing home. Why is that clear? Because the DRA of 2005 requires the state to be named as a beneficiary (primary or behind certain other eligible beneficiaries) of the annuity.

While the state must be named, its claim is limited to the amount of care paid on behalf of the institutionalized spouse–something that is recommended to put right in the beneficiary declaration on the annuity application. In short, it's not always possible to tell which spouse will be institutionalized until crisis strikes.

Additionally, creating a Medicaid SPIA sooner in the one-half deduction states can penalize the community spouse. In most states that use the snapshot date to determine the community spouse resource allowance, the CSRA is based on the value of countable assets on the snapshot date. If a patient has $300,000 on the snapshot date, their CSRA would max out at $157,920 in 2025. They could then convert $142,080 into a Medicaid qualified SPIA to complete the spending down.

However, if they did the same Medicaid qualified SPIA before the snapshot date, their available resources on the snapshot date (2025) would be $157,920. Since the CSRA is based on one-half of that amount, they would have to spend an additional $78,960 before becoming Medicaid eligible, leaving the community spouse with half of the allowance they should have had.

In 2013, the U.S. District Court for the Northern District of Ohio addressed the state's treatment of Medicaid-compliant annuities in *Hughes v. Colbert*. The case involved Carole Hughes, who entered a nursing home, and her husband, Harry Hughes, who purchased an annuity for himself using funds from his IRA. The Ohio Department of Job and Family Services (ODJFS) deemed this purchase an improper transfer of assets, as it exceeded the Community Spouse Resource Allowance (CSRA), and imposed a penalty period during which Mrs. Hughes was ineligible for Medicaid coverage.

The district court upheld the state's decision, interpreting federal Medicaid law to mean that transfers exceeding the CSRA are improper, even if made before Medicaid eligibility determination. The court also held that the annuity did not meet the requirements to be considered a non-countable asset, as it failed to name the state as the primary remainder beneficiary.

However, the U.S. Court of Appeals for the Sixth Circuit in Hughes v. McCarthy later reversed this decision, 734 F.3d 473 (6th Cir. 2013). The appellate court ruled that the purchase of an actuarially sound annuity by the community spouse before Medicaid eligibility determination is not an improper transfer, and that such annuities do not need to name the state as the primary remainder beneficiary. This decision aligned with federal law, which allows certain transfers for the sole benefit of the community spouse without penalty.

The Sixth Circuit's ruling clarified that, under federal Medicaid provisions, community spouses can purchase qualifying annuities without affecting the institutionalized spouse's Medicaid eligibility, provided the annuity is actuarially sound and meets specific criteria. This case significantly impacted on Medicaid planning strategies in Ohio and other states within the Sixth Circuit's jurisdiction.

For those readers who did not take civil procedure in law school, a federal district court's opinion is appealed first to the circuit court. A circuit covers several states, and when a circuit court rules on something, it is binding in those states. Taking a case to the circuit court is a large gamble. If you win, you set a precedent for a whole region of the country. If you lose, you take a bad decision in one part of one state and expand it to all the states in the circuit. In the 6th Circuit, which could have spelled trouble for everyone in Michigan, Ohio, Kentucky, and Tennessee, potentially set a bad precedent for other states.

Fortunately, the gamble paid off. The 6th Circuit Court issued a well-drafted opinion which struck down the state's view on Medicaid compliant annuities and affirmed the common planning technique used by Medicaid planners throughout the country (Hughes et al.v. McCarthy, 6th Circuit Court of Appeals, No. 12-3765, October 25, 2013).

Note: Following the U.S. Court of Appeals for the Sixth Circuit's decision in *Hughes v. McCarthy*, 734 F.3d 473 (2013), the state of Ohio sought further review by filing a petition for a writ of certiorari to the U.S. Supreme Court. The petition was docketed on January 28, 2014, under case number 13-898. However, on March 31, 2014, the Supreme Court denied the petition, thereby leaving the Sixth Circuit's ruling in place

The effect of this ruling cannot be understated. This case marks one of the highest rulings in favor of Medicaid compliant annuity planning. It gives judicial support to the common asset conversion techniques used by Medicaid planners and a full-throated opinion in favor of the proper use of Medicaid compliant annuities in crisis planning cases.

Asset conversion is essential for the ability to take retirement assets and turn them into something akin to a pension plan for a healthy spouse. Without the ability to do that, Congress recognized that it would be a huge disincentive for people to save their resources for retirement. If Congress had wanted to limit when the conversion could occur, they would have done so specifically. It is reprehensible for a state to set a limit, but they often get away with this because few people stand up and challenge it.

Remember, when a state gets more restrictive, they violate a patient's rights; if we let that happen, everybody loses. And by everybody, I'm referring to the struggling community spouses who often far outlive their spouses in the nursing home. They need to rely on asset conversion to make sure they have enough income to survive. They often have not planned and need to react to a severe long-term care crisis that threatens them with financial ruin and threatens to deplete their entire life's savings. The strategic use of the Medicaid compliant annuity allows for Medicaid planners and knowledgeable annuity

producers to provide meaningful help to these retirees, and now the 6th Circuit Court has given them a strong vote of support.

Medicaid Planning and IRAs

For many Medicaid applicants, individual retirement accounts (IRAs) are one of their biggest assets. If the applicant does not plan properly, IRAs can count as an available asset and affect their Medicaid eligibility.

Medicaid applicants can have only a small amount of assets to receive benefits ($2,000 in most states). Certain assets–i.e., houses, cars, and plots–are exempt from eligibility determinations. Whether your IRA counts as an exempt asset depends on whether it is in "payout" status" or not.

IRA in Payout Status

The SECURE Act of 2022 (Section 107) amends the RMD start ages for IRAs (and qualified retirement plans) it increased the RMD age to 73 starting in 2023 and further increases the RMD age to 75 starting in 2033 for individuals born on or after January 1, 1960, which means the IRA is in payout status. The applicant/resident may also be able to choose to put their IRA in payout status as young as age 59½ if they elect to take regular, series of periodic payments based on life expectancy tables.

If an IRA is in payout status, depending on the applicant's/resident's state, it may not count as an available asset for the purposes of Medicaid eligibility, but the payments the applicant/resident receives will count as income. Medicaid recipients can keep a tiny amount of income for personal use (personal needs allowance). The rest will go to the nursing home.

If the IRA is not in payout status, the IRA is a non-exempt asset, which means the total amount in the IRA will probably be counted as an asset, affecting the applicant's Medicaid eligibility. The applicant will need to cash out their IRA and spend down the assets to qualify for Medicaid. Alternatively, the applicant could transfer the money to their spouse or someone else. However, there will be an income tax penalty for doing this.

Note that the rules for a Roth IRA may be different. If the applicant has a Roth IRA, depending on the rules in their state, it may not be exempt at all because Roth IRAs do not require minimum distributions.

The rules regarding IRAs and Medicaid are complicated and vary from state to state. As your client's advisor, you should have your clients consult with an Elder Law attorney to determine the best course of action for them.

Below are some recent court cases that have examined whether Individual Retirement Accounts (IRAs) in payout status are considered non-countable assets for Medicaid eligibility. The treatment of such IRAs varies by state, and judicial decisions reflect these differences.

1. ***Matter of Estate of DeMartino*** **(New York, 2022)**

- **Court**: Appellate Division of the Supreme Court of New York
- **Date**: March 3, 2022
- **Summary**: The case involved an individual who had an IRA in payout status and applied for Medicaid benefits. The local Medicaid agency counted the IRA as a resource, leading to a denial of benefits.
- **Court's Reasoning**: The court held that under New York law, an IRA in payout status is considered an exempt resource for Medicaid eligibility purposes. The court emphasized that the regular distributions from the IRA are treated as income, not as a countable asset.
- **Outcome**: The court reversed the Medicaid agency's decision, ruling that the IRA in payout status should not be counted as an asset, thereby qualifying the individual for Medicaid benefits.

2. ***Hughes v. McCarthy*** **(Ohio, 2015) Discussed** above

- **Court**: United States Court of Appeals for the Sixth Circuit
- **Date**: August 18, 2015
- **Summary**: This case addressed whether an IRA owned by a community spouse in payout status should be considered a countable resource when determining the institutionalized spouse's Medicaid eligibility.
- **Court's Reasoning**: The court concluded that, according to Ohio's Medicaid regulations, the community spouse's IRA in payout status is not a countable resource. The court reasoned that the distributions from the IRA are considered income, and the principal of the IRA is exempt from being counted as an asset.
- **Outcome**: The court affirmed that the community spouse's IRA in payout status is a non-countable asset for Medicaid eligibility purposes.

3. ***Geston v. Anderson*** **(North Dakota, 2013)**

- **Court**: United States Court of Appeals for the Eighth Circuit
- **Date**: August 6, 2013
- **Summary**: The case involved a Medicaid applicant whose IRA was in payout status. The state Medicaid agency considered the IRA as a countable resource, leading to a denial of benefits.
- **Court's Reasoning**: The court determined that under North Dakota law, an IRA in payout status is not a countable resource for Medicaid eligibility. The court highlighted that the regular distributions are treated as income, and the principal amount of the IRA is exempt.

- **Outcome**: The court ruled in favor of the applicant, stating that the IRA in payout status should not be counted as an asset, thus qualifying the individual for Medicaid benefits.

These cases illustrate that the classification of IRAs in payout status as countable or non-countable assets for Medicaid eligibility is contingent upon state-specific regulations and judicial interpretations. Individuals seeking to protect their IRAs in the context of Medicaid planning should consult with legal professionals familiar with their state's Medicaid laws.

Use of Annuity in an IRA

Let's review the background of Hughes et al.v. McCarthy, 6th Circuit Court of Appeals, No. 12-3765, October 25, 2013) court ruling in which an annuity was purchased in the IRA and the state of Ohio Department of Medicaid denied Medicaid eligibility to Mrs. Hughes, however, was later reversed and Medicaid eligibility was granted.

Mrs. Hughes entered a nursing home in 2012. For nearly four years, Mr. Hughes paid for his wife's nursing home costs using the couple's resources, largely consisting of funds from his IRA account. In June 2016, about three months before Mrs. Hughes applied for Medicaid coverage, Mr. Hughes purchased a $175,000 immediate single-premium annuity for himself using funds from his IRA account. The annuity guarantees monthly payments of $1,728.42 to Mr. Hughes from June 2016 to January 2026, totaling nine years and seven months, commensurate with Mr. Hughes's undisputed actuarial life expectancy.

Combined with other retirement income, the annuity increased Mr. Hughes's monthly income to $3,460.64 after the annuity took effect. In the event of Mr. Hughes's death, Mrs. Hughes is the first contingent beneficiary, and the Ohio agency is "the remainder beneficiary for the total amount of medical assistance furnished to annuitant's spouse, Mrs. Hughes."

Mrs. Hughes applied for Medicaid coverage in September 2016. In December 2016, the Stark County division of the Ohio agency issued a notice that she was eligible for Medicaid as of the month of her application. However, the Ohio agency placed her on restricted coverage from September 2016 to June 2017, deeming her ineligible for coverage of nursing home costs for that time because of Mr. Hughes's annuity purchase.

The Ohio agency determined that Mr. Hughes's annuity purchase was an improper transfer because he used a community resource (the IRA account) in an amount that exceeded his CSRA, at the time (2016) of $119,220 and because the annuity failed to name Ohio as the first contingent beneficiary. Thus, the Ohio agency placed Mrs. Hughes on restricted coverage for approximately ten months, the number of months that the difference between Mr. Hughes's CSRA and the annuity would have paid for nursing home costs.

The Hughes' appealed the decision. The Ohio agency affirmed in a state-hearing and administrative-appeal level decision. State court proceedings have been stayed pending this case's resolution.

In August 2010, the Hughes' filed this case under 42 U.S.C. § 1983, alleging that the Ohio agency violated the federal Medicaid statutes, including § 1396p (c)(2)(B)(i), when it placed Mrs. Hughes on restricted coverage due to Mr. Hughes' purchase of an annuity with funds from his IRA account. They claimed that the Medicaid statutes grant them the right to purchase an actuarially sound immediate single-premium annuity for the sole benefit of the community spouse. The district court granted summary judgment in favor of the Ohio agency. It denied Hughes' request for injunctive relief (see Hughes v. Colbert, 872 F. Supp. 2d 612 N.D. Ohio 2012). The Hughes' appealed again.

The primary issue on appeal was whether the transfer of a community resource to purchase a Medicaid Compliant Annuity for the community spouse, which transfer is done after institutionalization but before Medicaid eligibility is determined, can be deemed an improper transfer. The Ohio Department of Medicaid argued that Congress' intent was a result that would subordinate the § 1396p(c)(2)(B)(i) to § 13965r-5(f)(1) CSRA transfer cap. It was determined that "if Congress prefers the interpretation that applies § 1396p(c)(1)(F) notwithstanding § 1396p(c)(2)(B)(i), it need only amend the statute."

Thus the 6th Circuit has reversed the Circuit Court's grant of summary judgment and remanded for further proceedings consistent with their opinion. Bottom line: This decision presents a powerful Medicaid planning option in Ohio for married couples.

Medicaid and Promissory Notes

As discussed above, the DRA of 2005 aimed to eliminate transfer of asset strategies at the so-called "crisis" phase altogether, that is, last-minute transfers of assets just prior to or immediately after placement in a long-term care facility. However, the federal law left open one planning strategy, in particular planning via a promissory note.

The federal law specifically permits planning via a promissory note by disregarding the asset as countable if the note:

- Is actuarially sound.
- Provides for equal payments with no deferral or balloon payments; and
- Is not canceled upon the death of the lender [42 U.S.C.§1396p(c)(1)].

Following these specific requirements, the use of promissory notes became de rigueur for Medicaid asset protection planning.

However, as could be anticipated, many states have challenged promissory notes when determining Medicaid eligibility. This has left Elder Law attorneys and their clients

fretting about the status of this federally authorized and heretofore permitted planning strategy, requiring practitioners to be alert as they pursue this strategy.

How It Works

In general, a promissory note is a contract wherein the maker of the note makes an unconditional promise in writing to pay a sum of money to the payee either at a fixed or determinable future time or on demand of the payee. The Medicaid planning context works as follows: The applicant/resident transfers all his funds (less the permissible resource allowance) to an individual (typically a family member).

The person receiving the funds signs a note promising to pay back approximately one-half of the money transferred (the loaned assets), plus interest, to the resident every month. The monthly amount to be paid back to the applicant/resident is calculated using the long-term care facility's daily rate less the applicant's/resident's income. Upon payment of the monthly amount to the applicant/resident, the applicant/resident writes a check for the same amount to the facility. The note repayment amount covers payment to the facility during the penalty period incurred by the transfer of the other one-half of the assets (the gifted assets).

> ***For Example****:* Mr. Smith transferred a total of $420,407.96 to his daughter on September 30, 2024, as a part-gift/part-loan transaction. Let's assume the nursing home daily rate is $425, and Mrs. Smith's monthly income totals $1,854. To determine the monthly loan repayments, Mr. Smith calculates the actual monthly cost at the facility's private pay rate for each month (30 or 31 days) less his monthly income. He then calculates the average of the monthly payments during the term of the penalty period (number of months) and factors in an interest rate (typically 5 percent). Here, the average monthly loan re-payment amount is $10,908.40 per month. This is the amount that Mr. Smith's daughter will pay back to him each month and which he will then turn over to the long-term care facility. The term of the loan will be 20 months beginning in October 2024. As such, $208,907.96 will be the total loan amount, and $211,500 will be the total gift made to Mr. Smith's daughter, which amount is free and clear to her. After 20 months, the loan will be repaid, the gifted money will be protected, and Mr. Smith eligible for Medicaid benefits.

For the strategy to work, there must be a monthly shortfall in the amount paid to the nursing home each month. This is so because the resident must have medical expenses greater than the Medicaid rate to be considered "otherwise eligible" for Medicaid benefits while also having medical expenses he is unable to meet in full [42 U.S.C. 1396p (c)(1)(D)(ii)].

As a rule, the promissory note strategy can only be employed when an applicant is already in a long-term care facility and is receiving services. Under the federal law, it is almost a condition precedent that a Medicaid applicant (the lender) be placed in a health care facility such that they can engage in promissory note planning because the applicant must be "otherwise eligible" for Medicaid, that is, both below the resource limit and in

the facility receiving care, before a penalty period can commence [42 U.S.C. 1396p (c)(1)(D)(ii)].

Once again, as the advisor, you need to emphasize to your clients the need for them to consult with a knowledgeable Elder Law attorney who can properly draft the promissory note and to make sure that the payments are made as required by the terms of the note so that Medicaid eligibility should occur at the expiration of the penalty period and promissory note.

Medicaid Estate Recovery Program (MERP)

To recoup long-term care costs and other related Medicaid services, Congress in the Omnibus Budget Reconciliation Act of 1993 (OBRA) mandated that states implement estate recovery programs. The Centers for Medicare and Medicaid Services (CMS) have issued guidelines in the *State Medicaid Manual* that afford considerable flexibility. In response, states have initiated legislative, regulatory, and programmatic efforts to recover funds from the estates of certain beneficiaries.

Federal law requires states to seek recovery of the cost of nursing facility care, home and community-based services, and related hospital and prescription drug services provided to individuals who were fifty-five years old or older when they received Medicaid. The home and community-based services include homemaker services, home health aide services; personal care services; adult day care; respite care; case management, and others. States have the option of recovering any other Medicaid benefits, in addition to the above, received by a person fifty-five years old or older. People under age fifty-five who are permanent residents of nursing homes may also be subject to recovery under Medicaid.

No recovery can occur from the individual's estate until after the death of the Medicaid beneficiary and the beneficiary's spouse and only if there is no child under age twenty-one, blind, or disabled. What constitutes an estate? At a minimum, the estate means the individual's probated estate–property that passes to others under a will or under the succession laws in the absence of a will. Property that passes by joint ownership, insurance contract, life estate, or trust usually stands outside the individual's probated estate.

Status of Estate Recovery Program

Every state has implemented a Medicaid Estate Recovery Program; 47 states have legislative authority; only 2 (Alabama and Kentucky) have no legislative authority. Thirty-six states have regulations governing estate recovery, while 10 have none. Thirty-one states have other forms of guidance, such as program manuals or directives; 13 states have no such guidance.

Use of Liens

States may choose whether to use liens to protect the state's interest in the property of Medicaid beneficiaries. A lien is "a security device that binds property to a debt and puts a party on notice that someone besides the owner of the property has an interest in that property." The lien itself is not a claim; the lien is the notice, and the claim is the demand through which the state triggers action. To make a formal claim against the property, the state or other creditor usually must take further action, such as filing a judicial action to create a claim that a court may then grant or deny. This process may occur as part of probate proceedings or as a separate collection proceeding. Though, liens against real property are often "enforced" at the time the property is sold without going to court. Since one cannot convey clear title to property if a lien is attached, the settler must either satisfy the lien as part of the sale or go to court seeking removal of the lien. Thus, estate recovery may occur through a lien without a claim, through a claim without a lien, or through a lien that is then enforced by using a claim.

Estate recovery programs use two types of liens:

- Pre-death liens are imposed on the home of living enrollees determined to be "permanently institutionalized" and not likely to return home. These pre-death liens are called TEFRA liens since they must follow rules set out in the Tax Equity and Fiscal Responsibility Act of 1982; and
- Post-death liens often are part of the probate process and follow state law. However, federal law dictates certain notice requirements.

One way of ensuring recovery against an estate is to place a lien on the property of the Medicaid beneficiary. A lien is a piece of paper filed in the court clerk's office that gives notice of a charge against the property. The usual target of the lien is the individual's home. While the individual is alive, federal law sets certain limits on liens against the home. Liens may be used only to recover the cost of care of people permanently residing in a nursing home or other medical institutions. More importantly, the state cannot impose the lien if the individual has a spouse or child under age 21 or a blind or disabled person living in the home. In certain cases, the same applies if your sibling co-owns the house and lives there.

Role of Children

Children have no legal obligation to pay for their parents' care. A spouse may be legally responsible to help pay for the other spouse's care, but it is hard to enforce the responsibility if the spouse is unwilling. If Medicaid enters the picture, the special rules for spousal responsibility described above will apply.

Children often feel a moral or personal obligation to help pay for a parent's nursing home. A shortage of Medicaid eligible nursing home beds puts this perception to the test. Some nursing homes admit "private-pay" patients before Medicaid patients because private-pay rates are higher than what Medicaid pays. Giving priority to private-pay patients is permissible in many states but illegal in others.

In all states, federal law prohibits nursing homes from requiring private payments from families of a resident or requiring a period of private payment prior to applying for Medicaid coverage. That includes asking for deposits from beneficiaries who are approved for Medicaid but not yet receiving it at the time of admission. Nursing homes cannot obligate an adult child or other third party to guarantee to pay the nursing home's charges. The child's obligation extends only as far as their authority over the parents' assets.

> ***For Example:*** The child who is an agent under the durable power of attorney of a parent may be obligated as the agent to pay the nursing home bills out of the parent's assets, but not out of their own personal assets. Federal law also prohibits nursing homes from requiring patients to waive or even delay their right to apply to Medicare and/or Medicaid.

However, you need to be familiar with the possibility that your state has on the book's filial responsibility laws. Several states have filial responsibility laws that make children responsible for their parents' medical care.

Filial Responsibilities Laws

More than half of the states have "*filial responsibility*" laws that make adult children responsible for their parents' medical care if their parents can't pay. These rules do not apply when a patient qualifies for Medicare–in that case, the Medicare system pays. However, if a patient can't pay for the care received before qualifying for Medicare, filial responsibility laws could require the patient's child or children to pay. Most filial responsibility laws take an adult child's ability to pay into account. These laws are generally designed to minimize the parents' burden on the state's welfare system. Most allow any LTC provider to sue family members for payment. Still, others make failing to care for a parent a criminal offense.

Most states that have filial responsibility laws don't enforce them. Here's why: Most elders who can't pay for care receive federal assistance through Medicaid, and federal law specifically prohibits going after adult children. Also, most folks who need help paying for nursing home care qualify for Medicaid, and it's unusual for someone to rack up a large bill before qualifying. So, because there is little opportunity to apply filial responsibility laws, they rarely affect families.

In most states, for a child to be held accountable for a parent's bill, all these things would have to be true:

- The parent received care in a state that has a filial responsibility law.
- The parents did not qualify for Medicaid when receiving care.
- The parents do not have the money to pay the bill.
- The child has the money to pay the bill; and
- The caregiver chooses to sue the child.

Although, in practice, these laws rarely cause children to have to pay for their parents' bills, a 2012 Pennsylvania Appeals Court ruled that an adult son of a nursing home resident would have to pay his mother's $93,000 nursing home bill based on the Pennsylvania filial responsibility law. This is a rare case because 1) the mother made just enough money through a pension not to qualify for Medicaid, and 2) the court allowed a private institution to sue the son, whereas filial responsibility laws are generally designed to empower the state to recover payments to reduce the burden on welfare. While this is an unusual case, some practitioners wonder if rising care costs will cause more cases like this to surface.

Note: The Pennsylvania Supreme Court's decision was not to hear an appeal of last year's notable ruling by a Pennsylvania Appeals Court that a son is liable for his mother's nursing home bill under the state's filial responsibility law. (Health Care & Retirement Corporation of America v. Pittas (Pa. Super. Ct., No. 536 EDA 2011, May 7, 2012).

Further Reading

Elder Law Answers, "*Medicaid Planning*;" https://www.elderlawanswers.com/medicaid-planning

Kaiser Family Foundation, "*Medicaid and Family Planning: Background and Implications of the ACA*;" https://www.kff.org/report-section/medicaid-and-family-planning-medicaid-family-planning-policy/

AgingCare, "*Filial Responsibility Laws and Medicaid*;" https://www.agingcare.com/Articles/filial-responsibility-and-medicaid-197746.htm

Chapter 18
Review Questions

1. For transfers made after February 8, 2006, how many months is the so-called "look-back" period for all transfers?

( ) A. 36 months
( ) B. 60 months
( ) C. 12 months
( ) D. 24 months

2. True or False? A Revocable Trust is of no use in Medicaid planning.

( ) A. True
( ) B. False

3. Which of the following Special Needs Trusts consists of the beneficiary's own assets?

( ) A. First-Party Trust
( ) B. Third-Party Trust
( ) C. Pooled Trust
( ) D. Both B and C

4. Which of the following Acts of Congress mandated that states must implement estate recovery programs?

(A. Deficit Reduction Act of 2005
( ) B. Omnibus Budget Reconciliation Act of 1993 (OBRA)
( ) C. The Medicare Modernization Act of 2003
( ) D. Pension Protection Act of 2006

5. If a parent can't pay for his or her own medical bills in a nursing home, then under the *"filial responsibility"* laws, who is held responsible to pay for the parent's care?

(A. Any relatives
( ) B. The estate
( ) C. The federal government
( ) D. The adult children

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CHAPTER REVIEW ANSWERS

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